	Pennsylvania Department Of Human Services
ESC	Error Status CODE Descriptions
201	BILLING PROVIDER IDENTIFICATION NUMBER IS MISSING FROM CLAIM
202	BILLING PROVIDER IDENTIFICATION NUMBER IS IN INVALID FORMAT
203	DATE OF SERVICE IS PRIOR TO RECIPIENT CARD ISSUE DATE
204	RECIPIENT IDENTIFICATION NUMBER IS INVALID OR NOT FOUND ON THE CLIENT INFORMATION SYSTEM (CIS)
205	PRESCRIBING PRACTITIONER'S LICENSE NUMBER IS MISSING FROM THE CLAIM, NATIONAL PROVIDER IDENTIFIER (NPI) REQUIRED.
206	PRESCRIBER/ATTENDING LICENSE NUMBER IS NOT IN A VALID FORMAT
207	THE EMERGENCY INDICATOR ON THE CLAIM IS INVALID
208	PREGNANCY INDICATOR ON THE CLAIM IS INVALID
209	RECIPIENT CARD ISSUE INFORMATION IS NOT AVAILABLE
210	BRAND MEDICALLY NECESSARY INDICATOR / DISPENSE AS WRITTEN CODE IS INVALID
211	REFILL NUMBER INVALID
212	PRESCRIPTION (RX) NUMBER SUBMITTED IS NOT VALID.
213	PROGRAM EXCEPTION (PE) REQUIRED FOR PROFESSIONAL CLAIM FROM PROVIDER TYPE (PT) 03
214	DATE PRESCRIBED IS MISSING OR INVALID
215	DATE DISPENSED IS MISSING
216	DATE DISPENSED IS INVALID
217	NDC (NATIONAL DRUG CODE) IS MISSING FROM THE CLAIM
218	NDC (NATIONAL DRUG CODE) IS NOT IN A VALID FORMAT
219	QUANTITY DISPENSED IS MISSING
220	QUANTITY DISPENSED IS INVALID
221	DAYS SUPPLY MISSING
222	DAYS SUPPLY INVALID
223	A VALID DIAGNOSIS CODE IS REQUIRED BUT MISSING ON THIS CLAIM
224	DIAGNOSIS POINTER REQUIRED
225	REFERRING PHYSICIAN IS MISSING
226	REFERRING PHYSICIAN NUMBER IS MISSING
227	THIRD PARTY PAYMENT AMOUNT INVALID
228	MULTIPLE OTHER PAYER SEGMENTS WITH SAME PAYER CODE
229	INVALID SOURCE OF ADMISSION
231	PRESCRIPTION ORIGIN CODE IS INVALID
232	RECIPIENT ID INVALID FOR PHARMACY CLAIMS
233	UNITS OF SERVICE BILLED IS MISSING ON THE CLAIM OR CLAIM DETAIL
234	THE PROCEDURE CODE IS MISSING ON THE CLAIM DETAIL
237	AMOUNT BILLED EXCEEDS MAXIMUM ALLOWED
238	AMOUNT BILLED EXCEEDS MAXIMUM ALLOWED

239	THE DETAIL TO DATE OF SERVICE IS MISSING
240	THE DETAIL TO DATE OF SERVICE IS INVALID
241	ACCIDENT INDICATOR IS INVALID
242	SECONDARY DIAGNOSIS CODE INVALID
244	THIRD DIAGNOSIS CODE INVALID
245	THE OCCURRENCE CODE IS MISSING
246	FOURTH DIAGNOSIS CODE IS INVALID
247	MAXIMUM NUMBER OF CLAIM DETAILS HAS BEEN EXCEEDED AND CANNOT BE PROCESSED. PLEASE SPLIT YOUR CLAIM AND RESUBMIT
248	PLACE OF SERVICE IS MISSING
249	PLACE OF SERVICE IS INVALID ON THE CLAIM DETAIL
250	THIS CLAIM HAS NO DETAILS BILLED
251	FIRST MODIFIER CODE IS NOT A VALID MODIFIER
252	SECOND MODIFIER CODE IS NOT A VALID MODIFIER
253	THIRD MODIFIER CODE IS NOT A VALID MODIFIER
254	THE CLAIM HEADER PLACE OF SERVICE CODE IS NOT VALID
255	THE BILLING PROVIDER SERVICE LOCATION CODE IS NOT A VALID SERVICE LOCATION
256	THE RENDERING PROVIDER SERVICE LOCATION CODE IS NOT A VALID SERVICE LOCATION CODE
257	THE RENDERING PROVIDER SERVICE LOCATION CODE AT THE CLAIM HEADER IS NOT VALID
258	THE PRIMARY DIAGNOSIS CODE IS MISSING
259	DATE BILLED IS INVALID
260	THE UNITS OF SERVICE IS ZERO OR INVALID
261	TOOTH NUMBER MISSING
262	TOOTH NUMBER INVALID
263	TOOTH SURFACE CODE INVALID
264	THE DATE OF SERVICE IS MISSING
265	THE DATE OF SERVICE IS INVALID
266	INSUFFICIENT NUMBER OF VALID TOOTH SURFACE CODES
268	THE BILLED AMOUNT IS MISSING
269	THE BILLED AMOUNT IS INVALID
270	THE TOTAL BILLED AMOUNT IS MISSING
271	THE TOTAL BILLED AMOUNT IS INVALID
272	PRIMARY DIAGNOSIS CODE INVALID
273	TYPE OF BILL CODE IS MISSING FROM THE CLAIM
274	TYPE OF BILL CODE ON THE CLAIM IS NOT A VALID CODE
275	ADMISSION DATE IS MISSING ON THE CLAIM
276	ADMISSION DATE INDICATED ON THE CLAIM IS NOT A VALID VALUE

277	TYPE OF BILLING CODE INVALID
278	ADMISSION TYPE IS MISSING FROM THE CLAIM
279	ADMISSION TYPE ON THE CLAIM IS NOT VALID
280	PATIENT STATUS IS MISSING
281	PATIENT STATUS IS INVALID
282	THE CLAIM NUMBER OF COVERED DAYS IS MISSING
283	THE CLAIM NUMBER OF COVERED DAYS IS NOT IN A VALID FORMAT
284	DETAIL DATES NOT WITHIN HEADER FROM/THROUGH DATES
285	RECIPIENT CLAIM DATE OF BIRTH DOES NOT MATCH CLIENT INFORMATION SYSTEM (CIS) DATE OF BIRTH (DOB)
286	RECIPIENT CLAIM DATE OF BIRTH (DOB) DOES MATCH CLIENT INFORMATION SYSTEM (CIS) DATE OF BIRTH (DOB)
287	RECIPIENT CLAIM DATE OF BIRTH (DOB) DOES NOT MATCH CLIENT INFORMATION SYSTEM (CIS) DATE OF BIRTH
288	CLAIM DATE OF SERVICE is GREATER THAN RECIPIENT CLIENT INFORMATION SYSTEM (CIS) DATE OF DEATH (DOD)
291	PRIMARY OCCURRENCE CODE IS NOT A VALID VALUE
292	SECOND OCCURRENCE CODE IS NOT A VALID VALUE
293	THIRD OCCURRENCE CODE IS NOT A VALID VALUE
294	FOURTH OCCURRENCE CODE IS INVALID
295	OCCURRENCE CODE IS PRESENT BUT THE OCCURRENCE DATE IS MISSING
296	OCCURRENCE CODE IS PRESENT BUT THE OCCURRENCE DATE IS INVALID
297	ADMISSION DATE IS MISSING WHERE DETAIL PLACE OF SERVICE (POS) IS 21 - INPATIENT (HEADER)
301	UNUSED
339	THE REVENUE CODE IS MISSING FROM THE CLAIM OR NOT A VALID VALUE
340	REVENUE CODE IS NOT VALID FOR THIS TYPE OF BILL
351	REFILLS ARE NOT ALLOWED FOR NARCOTIC DRUGS
354	GROSS PATIENT PAY INDICATED ON THE CLAIM IS NOT VALID
355	FIFTH DIAGNOSIS CODE IS INVALID
356	SIXTH DIAGNOSIS CODE IS INVALID
357	SEVENTH DIAGNOSIS CODE IS INVALID
358	EIGHTH DIAGNOSIS CODE IS INVALID
359	THE DIAGNOSIS CODE IS INVALID
361	ADMITTING DIAGNOSIS CODE INVALID
363	PRINCIPAL ICD (International Classification of Diseases) PROCEDURE CODE IS NOT VALID
364	PRINCIPAL PROCEDURE CODE OR DATE IS MISSING FROM THE CLAIM AND BOTH ARE REQUIRED
365	PRINCIPAL PROCEDURE DATE INVALID
366	SECOND PROCEDURE CODE INVALID
367	SECOND PROCEDURE CODE OR DATE IS MISSING FROM THE CLAIM AND BOTH ARE REQUIRED
368	SECOND PROCEDURE DATE INVALID
369	THIRD PROCEDURE CODE INVALID

370	THIRD PROCEDURE CODE OR DATE IS MISSING FROM THE CLAIM AND BOTH ARE REQUIRED
371	THIRD PROCEDURE DATE INVALID
372	FOURTH PROCEDURE CODE INVALID
373	FOURTH PROCEDURE CODE OR DATE IS MISSING FROM THE CLAIM AND BOTH ARE REQUIRED
374	FOURTH PROCEDURE DATE INVALID
375	FIFTH PROCEDURE CODE INVALID
376	FIFTH PROCEDURE CODE OR DATE IS MISSING FROM THE CLAIM AND BOTH ARE REQUIRED
377	FIFTH PROCEDURE DATE INVALID
378	SIXTH PROCEDURE CODE INVALID
379	SIXTH PROCEDURE CODE OR DATE IS MISSING FROM THE CLAIM AND BOTH ARE REQUIRED
380	SIXTH PROCEDURE DATE INVALID
381	ATTENDING/SUPERVISING PHYSICIAN LICENSE NUMBER IS MISSING FROM THE CLAIM
382	ATTENDING/SUPERVISING PHYSICIAN IDENTIFICATION IS NOT A VALID IDENTIFIER
383	FIRST OTHER PHYSICIAN IDENTIFICATION ON THE CLAIM DETAIL IS NOT VALID
384	SECOND OTHER PHYSICIAN IDENTIFICATION ON THE CLAIM DETAIL IS NOT VALID
385	FIRST OTHER PHYSICIAN IDENTIFICATION ON THE CLAIM HEADER IS NOT VALID
386	SECOND OTHER PHYSICIAN IDENTIFICATION ON THE CLAIM HEADER IS NOT VALID
387	OCCURRENCE SPAN FROM DATE IS PRESENT BUT NOT NUMERIC
388	REFERRING PROVIDER NOT ON FILE (OUTPATIENT CLAIM)
389	REVENUE CODE REQUIRES A CORRESPONDING HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS) / CURRENT PROCEDURAL TERMINOLOGY 4 (CPT-4) FOR OUTPATIENT BILLING
390	OCCURRENCE SPAN TO DATE IS GREATER THAN THE ADMISSION DATE AND OCCURRENCE SPAN CODE BILLED IS 71
392	OCCURRENCE SPAN TO DATE PRESENT BUT NOT NUMERIC
395	STATEMENT COVERS PERIOD "FROM" DATE MISSING
396	STATEMENT COVERS PERIOD "FROM" DATE INVALID
397	STATEMENT COVERS PERIOD "THROUGH" DATE IS MISSING
398	STATEMENT COVERS PERIOD "THROUGH" DATE IS INVALID
403	SPBP (SPECIAL PHARMACEUTICAL BENEFITS PROGRAM) - SELECT PROFESSIONAL & OUTPATIENT SERVICES ONLY
404	HOSPITAL "TO" DATE INVALID
405	FIFTH OCCURRENCE CODE IS NOT A VALID VALUE
406	SIXTH OCCURRENCE CODE IS NOT A VALID VALUE
407	SEVENTH OCCURRENCE CODE IS NOT A VALID VALUE
408	EIGHTH OCCURRENCE CODE IS NOT A VALID VALUE
409	FIRST OCCURRENCE SPAN CODE IS NOT A VALID VALUE
410	SECOND OCCURRENCE SPAN CODE IS NOT A VALID VALUE
419	FROM DATE OF SERVICE FOR FIRST SPAN CODE IS MISSING
420	FROM DATE OF SERVICE FOR FIRST SPAN CODE IS NOT VALID

421	TO DATE OF SERVICE FOR FIRST SPAN CODE IS MISSING
422	TO DATE OF SERVICE FOR FIRST SPAN CODE IS NOT A VALID VALUE
423	FROM DATE OF SERVICE FOR SECOND SPAN CODE MISSING
424	FROM DATE OF SERVICE FOR SECOND SPAN CODE IS NOT A VALID VALUE
425	TO DATE OF SERVICE FOR SECOND SPAN CODE MISSING
426	TO DATE OF SERVICE FOR SECOND SPAN CODE IS NOT A VALID VALUE
427	Surgery Priced at Zero as a Result of Multiple Surgeries
430	ONLY PARTIAL UNITS HAVE BEEN BILLED. BILL USING FULL UNIT VALUES
433	CLAIM DETAIL DEDUCTIBLE AMOUNT IS NOT VALID - DETAIL
434	CLAIM DETAIL COINSURANCE AMOUNT IS NOT VALID - DETAIL
436	CLAIM DETAIL MEDICARE ALLOWED AMOUNT IS NOT VALID - DETAIL
437	CLAIM HEADER DEDUCTIBLE AMOUNT IS NOT VALID - HEADER
438	CLAIM HEADER COINSURANCE AMOUNT IS NOT VALID - HEADER
439	CLAIM TOTAL MEDICARE ALLOWED AMOUNT IS NOT VALID - HEADER
440	NO MEDICARE DEDUCTIBLE / COINSURANCE DUE FROM MEDICAL ASSISTANCE (MA)
441	MEDICARE AMOUNTS MUST BE AT SERVICE LINE LEVEL
442	MEDICARE PAID AMOUNT INVALID - DETAIL
443	MEDICARE PAID AMOUNT IS REQUIRED
444	MEDICARE PAID AMOUNT INVALID - HEADER
445	REVIEW MEDICARE PAID AMOUNT. FAX EOMB (Explanation of Medical Benefits) TO THIRD PARTY LIABILITY (TPL) AT 717-772-6598 FOR REVIEW
446	REVIEW MEDICARE THRESHOLD AMOUNT. FAX EOMB (Explanation of Medical Benefits) TO THIRD PARTY LIABILITY (TPL) AT 717-772-6598 FOR REVIEW
447	MEDICARE DOES NOT COVER/PAYS SERVICE IN FULL.
448	CLAIM ADJUSTMENT REASON CODE (CARC) 94 - MEDICARE IPPS PAYMENT IS GREATER THAN THE BILLED AMOUNT
449	MEDICARE APPROVED AMOUNT MISSING - HEADER
450	INVALID TOOTH QUADRANT INDICATED
451	ENCOUNTER INVALID QUADRANT
453	CLAIM DETAIL RENDERING PROVIDER SERVICE LOCATION IS MISSING - DETAIL
454	CLAIM HEADER RENDERING PROVIDER SERVICE LOCATION IS MISSING - HEADER
455	DENTAL PREDETERMINATION OF BENEFITS NOT ALLOWED IN THIS FORMAT
456	INVALID PROCEDURE TYPE
457	MEDICARE APPROVED AMOUNT MISSING - DETAIL
458	REVIEW THIRD PARTY LIABILITY (TPL) PAID AMOUNT. FAX EOMB TO THIRD PARTY LIABILITY (TPL) AT 717-772-6598 FOR REVIEW.
459	MANUALLY REVIEW PAPER OUTPATIENT CROSSOVER CLAIM
460	MEDICARE CAPPED/MEDICARE LIMITED SERVICES-EXPLANATION OF MEDICAL BENEFITS REQUIRED
461	VALUE CODE INDICATED IS NOT A VALID VALUE
462	VALUE CODE AMOUNT MISSING

471	CONDITION CODE BILLED IS NOT A VALID VALUE
472	CLAIM LINE BILLED AMOUNT DOES NOT EQUAL CALCULATED BILLED AMOUNT
473	COVERED DAYS NOT EQUAL TO THE SUM OF FACILITY DAYS, HOSPITAL LEAVE DAYS, AND THERAPEUTIC LEAVE DAYS
474	FULL MEDICARE DAYS IS NOT NUMERIC
476	MEDICARE DEDUCTIBLE HAS BEEN BILLED AND YOU HAVE INCLUDED MORE THAN ONE YEAR IN YOUR DATES OF SERVICE. PLEASE RESUBMIT SEPARATE INVOICES FOR DIFFERENT YEARS - DETAIL
477	MEDICARE DEDUCTIBLE HAS BEEN BILLED AND YOU HAVE INCLUDED MORE THAN ONE YEAR IN YOUR DATES OF SERVICE. PLEASE RESUBMIT SEPARATE INVOICES FOR DIFFERENT YEARS - HEADER
480	MORE THAN ONE MEDICARE IDENTIFICATION EXISTS FOR THE DATES OF SERVICE
481	CLAIM DETAIL MEDICARE APPROVED AMOUNT IS LESS THAN THE MEDICARE DEDUCTIBLE AMOUNT
482	CLAIM HEADER MEDICARE APPROVED AMOUNT IS LESS THAN THE MEDICARE DEDUCTIBLE AMOUNT
483	VALUE CODES AND VALUE AMOUNTS ARE INCONSISTENT WITH THE DEDUCTIBLE AND COINSURANCE AMOUNTS FOR PRIVATE INSURANCE AND / OR MEDICARE
484	BLOOD DEDUCTIBLE INFORMATION IS INVALID
485	BLOOD DEDUCTIBLE AMOUNTS EXCEED THE MAXIMUM ALLOWED
486	UNKNOWN EDIT #2 (05/26/2010)
487	THIS CLAIM WAS SUBMITTED TO THE DEPARTMENT AS A MEDICARE CROSSOVER CLAIM
488	MEDICARE COINSURANCE IS GREATER THAN ZERO AND GREATER THAN THE APPROVED AMOUNT ON THIS CLAIM DETAIL
489	MEDICARE COINSURANCE GREATER THAN ZERO AND GREATER THAN APPROVED AMOUNT ON THIS CLAIM
490	MEDICARE COINSURANCE GREATER THAN ZERO MINUS THE APPROVED AMOUNT IS LESS THAN OR EQUAL TO ZERO FOR THIS CLAIM DETAIL
491	MEDICARE A COST SHARING - MEDICARE PAID ZERO OR MISSING
492	DEDUCTIBLE AMOUNT IS GREATER THAN THE APPROVED AMOUNT OR APPROVED AMOUNT IS EQUAL TO ZERO
493	THE COVERED DAYS BILLED IS INVALID
494	MEDICARE ALLOWED AMOUNT IS INVALID
495	MEDICARE PAID AMOUNT IS GREATER THAN ZERO BUT THE APPROVED AMOUNT IS LESS THAN OR EQUAL TO ZERO ON THIS CLAIM DETAIL
496	PROCEDURE CODE IS AN EMERGENCY CODE AND EMERGENCY INDICATOR ON THE CLAIM DOES NOT AGREE
497	NET PATIENT PAY DOES NOT EQUAL GROSS PATIENT PAY MINUS DRUG DEDUCTION, INSURANCE PREMIUM, AND OTHER MEDICAL EXPENSES.
498	THE TOTAL CHARGES AMOUNT MUST CONTAIN ALL NUMBERS.
499	MEDICARE COINSURANCE IS GREATER THAN ZERO MINUS THE APPROVED AMOUNT IS LESS THAN OR EQUAL TO ZERO AT THE CLAIM HEADER
500	THE CLAIM DATE PRESCRIBED IS AFTER THE CLAIM BILLING DATE
501	PROCEDURE CODE INCOMPATIBLE WITH THE EMERGENCY INDICATOR
502	THE DATE DISPENSED IS EARLIER THAN THE DATE PRESCRIBED
503	THE DATE DISPENSED IS AFTER THE CLAIM BILLING DATE
504	MEDICARE PAID AMOUNT IS GREATER THAN ZERO BUT THE APPROVED AMOUNT IS LESS THAN, OR EQUAL TO, ZERO FOR THIS CLAIM
506	THE CLAIM DATE BILLED IS AFTER THE RECEIPT DATE IN THE INTERNAL CONTROL NUMBER (ICN) OF THE CLAIM

507	THE "FROM" DATE IS AFTER THE "TO" DATE
508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL LINE CHARGES
510	THE FIRST OCCURRENCE SPAN THROUGH DATE IS BEFORE THE FIRST OCCURRENCE SPAN FROM DATE
511	THE SECOND OCCURRENCE SPAN THROUGH DATE IS BEFORE THE SECOND OCCURRENCE SPAN FROM DATE
512	THE CLAIM IS PAST THE 365 DAY FILING LIMIT - DETAIL
513	THE CLAIM IS PAST THE 365 DAY FILING LIMIT - HEADER
514	THE CLAIM HEADER THROUGH DATE OF SERVICE IS AFTER INTERNAL CONTROL NUMBER (ICN) DATE
515	AN OUTPATIENT PLACE OF SERVICE WAS BILLED HOWEVER RECIPIENT WAS AN INPATIENT ON THE CLAIM LINE DATE OF SERVICE
516	THIS CLAIM WAS SUBMITTED ON BEHALF OF THE DEPARTMENT OF HUMAN SERVICES (DHS)
517	THIS CLAIM WAS VOIDED ON BEHALF OF THE DEPARTMENT OF HUMAN SERVICES (DHS)
519	ADMISSION DATE IS AFTER THE STATEMENT PERIOD "FROM" DATE
520	INVALID DATE OF SERVICE - (INACTIVE)
526	DATE OF SERVICE IS AFTER INTERNAL CONTROL NUMBER (ICN) DATE - HEADER
527	DATE OF SERVICE IS AFTER INTERNAL CONTROL NUMBER (ICN) DATE - DETAIL
528	INVALID DISCHARGE STATUS
529	THE STATEMENT COVERS PERIOD "FROM" DATE IS AFTER THE "TO" DATE - HEADER
531	UNKNOWN EDIT
532	REVENUE CODE / PROVIDER SPECIALTY MISMATCHED
534	THE PROCEDURE CODE CLAIM TYPE AND TYPE OF BILL VALUES ARE NOT ALLOWED - DETAIL
545	CLAIM IS PAST THE TIMELY FILING LIMIT - DETAIL
546	CLAIM IS PAST THE TIMELY FILING LIMIT - HEADER
549	NOT USED
550	THE CLAIM ADJUSTMENT BILLED WAS NOT PROCESSED
551	BILLING PROVIDER ID / LOCATION DOES NOT MATCH ORIGINAL CLAIM
552	NATIONAL PROVIDER IDENTIFIER (NPI) CROSS WALK RESULT DOES NOT MATCH ON ADJUSTMENT
554	THE BILLED DATE IS LESS THAN THE DATES OF SERVICE ON THE CLAIM
568	DISCHARGE DATE IS LESS THAN THE ADMISSION DATE
569	NOT USED
570	NOT USED
572	ITEM DAYS NOT EQUAL TO COVERED DAYS ON CLAIM
573	TOTAL DAYS ON CLAIM CONFLICT WITH DATES SHOWN
574	CLAIM DETAIL SERVICE DATES MUST BE BILLED WITHIN THE SAME CALENDAR MONTH
575	SURGERY DATE CANNOT BE OUTSIDE OF THE CLAIM DATES OF SERVICE
576	CLAIM SERVICE DATES MUST BE BILLED WITHIN THE SAME CALENDAR MONTH
577	OTHER PAYER SEGMENT REQUIRED FOR ENCOUNTER CLAIMS
578	COVERED AND NON-COVERED DAYS DO NOT EQUAL DATES
579	CLAIM SUSPENSE FACILITY OTHER MEDICAL EXPENSES / SERVICES (OME) SHOULD NOT APPLY TO CLAIM

580	PROCEDURE CODE REQUIRES MODIFIER "VP"
581	OCCURRENCE SPAN THROUGH DATE IS LESS THAN THE OCCURRENCE SPAN FROM DATE AND THE OCCURRENCE SPAN CODE VALUE IS WITHIN THREE TO 25
582	VALUE CODE 54 PRESENT/NO BIRTH WEIGHT ON CLAIM
583	VALUE CODE 54/BIRTH WEIGHT IS NOT NUMERIC
584	VALUE CODE 54/BIRTH WEIGHT MUST BE WHOLE NUMBER
585	ADMISSION DATE DOES NOT EQUAL FIRST DATE OF SERVICE
586	BIRTH WEIGHT IS GREATER THAN FOUR-DIGITS
587	BIRTH WEIGHT < 200 GRAMS OR > 7000 GRAMS
588	GENERAL ASSISTANCE (GA) Deductible not assessed for Inpatient Emergency Admission
589	MASS ADJUSTMENT HAS SUSPENDED FOR MANUAL REVIEW
590	SUBMIT SEPARATE CLAIMS FOR BILLING JUNE THROUGH JULY HOSPITAL DAYS
591	STRAIGHT SERVICES MUST BE BILLED ON TYPE OF BILL 14
592	TYPE OF BILL 141 IS FOR SPECIAL TREATMENT 'SC' ONLY
593	THIRD PARTY LIABILITY (TPL) HEADER CARRIER DOES NOT MATCH DETAIL CARRIER
594	UNITS CANNOT BE LESS THAN DAYS
596	FILE SEPARATE CLAIMS FOR DIFFERENT CALENDAR YEARS
597	CLINICAL VISIT PROCEDURE CODE 'VS' MODIFIER
598	BIRTH WEIGHT GREATER THAN 9999 GRAMS OR INVALID
600	UNITS NOT EQUAL TO QUADRANTS BILLED
601	TOOTH NUMBERS NOT ALLOWED FOR QUADRANTS BILLED
602	UNITS NOT EQUAL TO TEETH BILLED
603	MULTIPLE TEETH PER DETAIL IS INVALID
605	ATTACHMENT CONTROL NUMBER (ACN) NOT ON FILE
606	ATTACHMENT CONTROL NUMBER (ACN) ALREADY ISSUED FOR ANOTHER CLAIM
607	PRESENT ON ADMISSION (POA) INDICATOR IS INVALID OR SPACES
608	NUMBER OF PRESENT ON ADMISSION (POA) NOT EQUAL TO NUMBER OF DIAGNOSIS CODES
609	MULTIPLE OTHER PAYER SEGMENTS WITH SAME PAYER CODE
610	WAIVER FOR SELECT PHYSICIAN
612	CONDITION CODE EQUAL 77
613	REVIEW MEDICARE COINSURANCE
614	VERIFY LIMITS OF THIS RECIPIENT'S THIRD PARTY COVERAGE
617	INVALID DATE OF DISCHARGE - (INACTIVE)
618	ADJUSTMENT INTERNAL CONTROL NUMBER (ICN) INVALID
620	YOUR CLAIM HAS REJECTED DUE TO NO MEDICARE APPROVED AMOUNT
621	THE CLAIM ADMISSION OR DISCHARGE DATE AND TYPE DO NOT AGREE
623	THE NON-COVERED DAYS BILLED ARE NOT NUMERIC

624	THE FACILITY, LEAVE, AND HOSPITAL DAYS MUST BE ALL NUMERIC.
625	THE FACILITY MEDICAL ASSISTANCE (MA) IDENTIFICATION NUMBER IS MISSING. IT IS REQUIRED FOR THE PLACE OF SERVICE INDICATED.
626	THE DISCHARGE HOUR IS INVALID OR PRESENT WHEN PATIENT STATUS EQUALS 30
627	THE TOTAL DUE FROM PATIENT AMOUNT SHOULD BE ALL NUMERIC.
629	THE PRIVATE DEDUCTIBLE ON YOUR INVOICE IS NOT NUMERIC
630	THE PRIVATE COINSURANCE ON YOUR INVOICE IS NOT NUMERIC
631	THE LIFE TIME RESERVE DAYS (L-RD) ON YOUR CLAIM ARE INVALID OR HAVE EXCEEDED 60 DAYS
632	COINSURANCE DAYS INDICATED ON YOUR INVOICE ARE INVALID
634	COINSURANCE DAYS INDICATED ON YOUR INVOICE IS BLANK
635	INPATIENT PER DIEM BILLING MEDICARE BLOOD DEDUCTIBLE
636	MATCH NOT FOUND FOR ORIGINAL INTERNAL CONTROL NUMBER (ICN) / CLAIM REFERENCE NUMBER (CRN), PAID STATUS, PROVIDER IDENTIFICATION AND RECIPIENT COMBINATION
637	THE PLACE OF SERVICE IS NOT ACCEPTABLE FOR THIS PROVIDER
638	THE ORIGINAL CLAIM HAS ALREADY BEEN ADJUSTED
639	THE ADJUSTMENT CODE DOES NOT AGREE WITH THE TYPE OF BILL CODE
640	THE MEDICARE DEDUCTIBLE AMOUNT ON THE INVOICE IS INCORRECT
642	THE ADMISSION HOUR ON THE CLAIM IS MISSING OR INVALID
643	THE DEPARTMENT HAS IDENTIFIED THAT THIS CLAIM IS NOT A VALID INTERIM BILL AND IDENTIFICATION IS LESS THAN NINETY DAYS
644	THE MEDICARE DEDUCTIBLE AMOUNT ON THE INVOICE IS INCORRECT
645	THE MEDICARE COINSURANCE AMOUNT ON THE INVOICE SHOULD EQUAL THE NUMBER OF COINSURANCE DAYS TIMES THE COINSURANCE RATE AND / OR THE LIFETIME RESERVE (LR) DAYS USED TIMES THE LIFETIME RESERVE RATE
646	YOU HAVE INDICATED MEDICARE DEDUCTIBLE OR MEDICARE CO-INSURANCE ON YOUR INVOICE / ADJUSTMENT AND THE TOTAL MEDICARE APPROVED AMOUNT IS BLANK OR CONTAINS ALL ZEROES FOR THIS CLAIM DETAIL
647	YOU HAVE INDICATED MEDICARE DEDUCTIBLE OR MEDICARE CO-INSURANCE ON YOUR INVOICE / ADJUSTMENT AND THE TOTAL MEDICARE APPROVED AMOUNT IS BLANK OR CONTAINS ALL ZEROES FOR THIS CLAIM
648	THE COVERED DAYS IS LESS THAN THE COMBINATION OF TOTAL DAYS
649	THE SUBMITTER IDENTIFICATION AND SERVICE LOCATION ARE NOT VALID
650	SUBMIT MEDICARE AMOUNTS AT THE CLAIM LINE LEVEL
651	PRIVATE COINSURANCE / DEDUCTIBLE MUST BE AT THE HEADER - NOT DETAIL
652	TPL (THIRD PARTY LIABILITY) PAID AT THE CLAIM LEVEL MUST BE AT THE SERVICE LINE
653	FEDERALLY QUALIFIED HEALTH CENTER (FQHC) / RURAL HEALTH CLINIC (RHC) MUST INCLUDE MEDICARE PAID AMOUNT
654	PRIMARY CARE PROVIDER (PCP) BILLED DEDUCTIBLE, COINSURANCE, OR CO-PAY NO THIRD PARTY LIABILITY (TPL) PAID
655	MORE THAN ONE CLAIM LINE BILLED ON A CROSS OVER CLAIM
656	THE CLAIM LINE INDICATES A HOSPITALIZATION AND THE DATE OF SERVICE IS NOT WITHIN ADMISSION AND DISCHARGE DATES
658	ADJUSTMENT INTERNAL CONTROL NUMBER (ICN) IS PRESENT BUT THE CLAIM INDICATES AN ORIGINAL CLAIM
660	CLAIM FREQUENCY CODE NOT SUPPORTED
661	IF THE CLAIM WAS DENIED BY THE MANAGED CARE ORGANIZATION (MCO) THEN THE AMOUNT REIMBURSED MUST EQUAL ZERO.

662	THE PLACE OF SERVICE INDICATED ON THIS CLAIM IS NOT VALID FOR THE CLAIM TYPE
663	CLAIM PREGNANCY INDICATION AND RECIPIENT GENDER DO NOT AGREE
664	ORIGINAL REFERENCE NUMBER MUST BE BLANK IF CLAIM FREQUENCY CODE = '1'
665	AMOUNT REIMBURSED INVALID FOR A VOID CLAIM
666	LONG TERM CARE (LTC) ENCOUNTERS MAY NOT SPAN MONTHS
667	SUSPENDED CLAIMS CANNOT BE REPLACED / VOIDED
668	CLAIM DETAIL COINSURANCE AMOUNT MUST BE ZERO IF MEDICARE APPROVED AMOUNT IS ZERO
669	MEDICARE COINSURANCE MUST BE LESS THAN OR EQUAL TO MEDICARE APPROVED
670	CLAIM DETAIL MEDICARE PAID AMOUNT MUST BE GREATER THAN ZERO IF THE MEDICARE COINSURANCE AMOUNT IS PRESENT
671	MEDICARE COINSURANCE DAYS MUST BE LESS THAN OR EQUAL TO QUANTITY BILLED
672	MEDICARE APPROVED AMOUNT MUST BE GREATER THAN ZERO FOR COINSURANCE DAYS TO BE BILLED / PAID
673	CLAIM COINSURANCE AMOUNT MUST BE ZERO IF THE CLAIM MEDICARE APPROVED AMOUNT IS ZERO
674	CLAIM MEDICARE COINSURANCE AMOUNT BILLED MUST BE LESS THAN OR EQUAL TO THE MEDICARE APPROVED AMOUNT
675	CLAIM MEDICARE PAID AMOUNT MUST BE GREATER THAN ZERO FOR MEDICARE COINSURANCE TO BE BILLED / PAID
676	ADMISSION HOUR MUST BE LESS THAN DISCHARGE HOUR FOR A SINGLE DAY OF SERVICE
678	DISCHARGE HOUR MUST BE PRESENT IF PATIENT HAS BEEN DISCHARGED
681	CLAIM DETAIL MEDICARE APPROVED AMOUNT MUST BE GREATER THEN ZERO WHEN MEDICARE PAID AMOUNT IS GREATER THAN ZERO
682	OCCURRENCE SPAN CODES REQUIRE OCCURRENCE SPAN DATES TO BE PRESENT
683	OCCURRENCE SPAN CODE MUST BE PRESENT
684	OCCURRENCE SPAN TO DATE MUST BE LESS THAN ADMISSION DATE
685	INVALID PATIENT DISCHARGE STATUS - HEADER
686	INVALID PATIENT DISCHARGE STATUS - HEADER
687	INVALID PATIENT DISCHARGE STATUS - HEADER
688	CLAIM MEDICARE APPROVED AMOUNT MUST BE GREATER THEN ZERO WHEN MEDICARE PAID AMOUNT IS GREATER THAN ZERO
689	PAYMENT ADJUDICATION DATE IS NOT VALID
690	QUANTITY BILLED DOES NOT EQUAL DAYS OF SERVICE BILLED
691	COINSURANCE AMOUNT MUST BE GREATER THAN ZERO WHEN COINSURANCE DAYS ARE GREATER THAN ZERO
692	QUANTITY MUST BE GREATER THAN ZERO
693	TOTAL CHARGES MUST BE GREATER THAN ZERO
694	MEDICARE APPROVED AMOUNT MUST BE GREATER THAN ZERO WHEN LIFETIME RESERVE DAYS
695	TOOTH NUMBER REQUIRED WHEN TOOTH SURFACE PRESENT
696	THE VISIT CODE INDICATED ON THE CLAIM IS NOT VALID
698	MEDICARE APPROVED AMOUNT MUST BE GREATER THAN ZERO IF LIFETIME RESERVE DAYS ARE GREATER THAN ZERO
699	LIFETIME RESERVE DAYS MUST BE BETWEEN ZERO AND 60
700	APPROVED - REJECTED INDICATOR DOES NOT EQUAL "9". AMOUNTS WILL NOT BE INCLUDED IN REPORTS
701	CN1 SEGMENT DATA INCONSISTENT - HEADER

702	CN1 SEGMENT DATA INCONSISTENT - DETAIL
703	INVALID PROCEDURE CODE MODIFIERS (PC/MOD) COMBINATION FOR TARGETED CASE MANAGEMENT (TCM)
704	INVALID PROVIDER INFORMATION FOR TARGETED CASE MANAGEMENT (TCM)
705	THE RECIPIENT'S AGE AS OF THE THROUGH DATE OF SERVICE CANNOT BE GREATER THAN 22 FOR RESIDENTIAL TREATMENT FACILITY (RTF) JOINT COMMISSION FOR THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) SERVICES.
706	RECIPIENT'S AGE AS OF THE THROUGH DATE OF SERVICE CANNOT BE GREATER THAN 22 FOR BEHAVIOR HEALTH PROVIDER SPECIALTY (BHPRS) OR RESIDENTIAL TREATMENT FACILITY (RTF) NON-JCAHO (JOINT COMMISSION FOR THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS) SERVICES.
707	INVALID COMBINATION FOR INSTITUTIONAL BEHAVIORAL HEALTH ENCOUNTER
708	INVALID COMBINATION FOR PROFESSIONAL BEHAVIORAL HEALTH ENCOUNTER
709	ENCOUNTER REPORTED DRG (DIAGNOSTIC RELATED GROUP) IS MISSING
710	ENCOUNTER REPORTED DRG (DIAGNOSTIC RELATED GROUP) IS INVALID
711	FIRST MODIFIER INVALID
712	SECOND MODIFIER INVALID
713	THIRD MODIFIER INVALID
714	FOURTH MODIFIER INVALID
715	PROCEDURE CODE/NDC (NATIONAL DRUG CODE) IS NOT COVERED FOR DATE OF SERVICE
717	INVALID COMBINATION FOR INSTITUTIONAL CONSOLIDATED COMMUNITY REPORTING / PERFORMANCE OUTCOME MEASUREMENT SYSTEM (CCR/EPOMS) ENCOUNTER
718	INVALID COMBINATION FOR PROFESSIONAL CONSOLIDATED COMMUNITY REPORTING / PERFORMANCE OUTCOME MEASUREMENT SYSTEM (CCR/EPOMS) ENCOUNTER
719	RECIPIENT IS NOT IN THE CONSOLIDATED COMMUNITY REPORTING / PERFORMANCE OUTCOME MEASUREMENT SYSTEM (CCR/EPOMS) SERVICE PROGRAM
720	CLAIM TYPE NOT VALID FOR THE CONSOLIDATED COMMUNITY REPORTING / PERFORMANCE OUTCOME MEASUREMENT SYSTEM (CCR/EPOMS)) SERVICE PROGRAM
721	REQUEST DENY, SEE CLAIM NOTE
722	ICD (International Classification of Diseases) PROCEDURE CODE NOT ON FILE
723	PRINCIPAL ICD PROCEDURE CODE NOT ON FILE OR NOT VALID FOR PROCEDURE DATE
724	SECOND ICD PROCEDURE CODE NOT ACTIVE ON DATE OF SERVICE
725	THIRD PROCEDURE CODE NOT ACTIVE FOR DATE OF SERVICE
726	FOURTH PROCEDURE CODE NOT ACTIVE FOR DATE OF SERVICE
727	FIFTH PROCEDURE CODE NOT ACTIVE FOR DATE OF SERVICE
728	SIXTH PROCEDURE CODE NOT ACTIVE FOR DATE OF SERVICE
729	REVENUE CODE NOT ON FILE
730	ADMITTING DIAGNOSIS CODE INVALID
731	PRIMARY DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE
732	SECONDARY DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE
733	THIRD DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE
734	FOURTH DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE (EMERGENCY)

735	FIFTH DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE
736	SIXTH DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE
737	SEVENTH DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE
738	EIGHTH DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE
739	DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE
740	INVALID OR MISSING POINTER ELEMENT FOR BUNDLED DETAIL LINE
741	INVALID COMBINATION FOR CONSOLIDATED COMMUNITY REPORTING / PERFORMANCE OUTCOME MEASUREMENT SYSTEM (CCR/EPOMS) INPATIENT FUNDING
742	INVALID COMBINATION FOR CONSOLIDATED COMMUNITY REPORTING / PERFORMANCE OUTCOME MEASUREMENT SYSTEM (CCR/EPOMS) PROFESSIONAL FUNDING
743	PAID AMOUNTS DO NOT BALANCE
750	REFERRING PROVIDER NUMBER IS NOT 13 DIGITS
751	INVALID REFERRAL CODE FOR ACCESS PLUS PRIMARY CARE PROVIDER (PCP)
752	ACCESS PLUS PRIMARY CARE PROVIDER (PCP) REFERRAL IS MISSING ON THE CLAIM
753	REFERRING PROVIDER IS NOT THE RECIPIENT'S PRIMARY CARE PROVIDER (PCP)
754	RENDERING PROVIDER IS PRIMARY CARE PROVIDER (PCP) - NOT THE RECIPIENT'S PRIMARY CARE PROVIDER (PCP)
755	THERE IS NO ACCESS PLUS PRIMARY CARE PROVIDER (PCP) ON FILE FOR RECIPIENT
756	MULTIPLE REFERRAL CODES FOR RECIPIENT
757	REFERRING PROVIDER / SERVICE LOCATION NOT PCP'S (PRIMARY CARE PROVIDER)
758	ACCESS PLUS SPECIAL INDICATOR MISSING OR INVALID
759	PRIMARY CARE PROVIDER (PCP) GROUP - NO ACTIVE PRIMARY CARE PROVIDER (PCP) GROUP MEMBERS
760	SERVICE DOES NOT REQUIRE PRIMARY CARE PROVIDER (PCP) REFERRAL
761	ACCESS PLUS PRIMARY CARE PROVIDER (PCP) PROVIDED SERVICE
762	NINE-DIGIT IS NOT PRIMARY CARE PROVIDER (PCP) IDENTIFICATION
763	NINE-DIGIT IDENTIFICATION SUBMITTED IN REFERRING ON CLAIM
770	RURAL HEALTH CLINIC (RHC) / FEDERALLY QUALIFIED HEALTH CENTER (FQHC) BILLED AMOUNT EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) COMPONENTS MUST BE $0.
771	BILLED AMOUNT MUST BE $0 (ZERO) FOR MODIFIERS 52 & 90
772	DATES OF SERVICE DO NOT MATCH UNITS ON CLAIM LINE
773	BILL ODP (OFFICE OF DEVELOPMENTAL PROGRAMS) INELIGIBLE SERVICE IN SUBSEQUENT MONTH. INELIGIBLE SERVICES DEPEND ON SSI (SUPPLEMENTAL SECURITY INCOME) PAYMENTS SUBMITTED ON THE CLAIM
774	RESIDENTIAL SERVICES CANNOT CROSS CALENDAR MONTHS
775	MORE THAN ONE UNIT BILLED FOR ADMINISTRATIVE FEE
776	CLAIM CANNOT SPAN FISCAL YEAR
777	BY-PASSED DATE OF DEATH EDIT.
778	CONSUMER CONTRIBUTION SUPPLEMENTAL SECURITY INCOME (SSI) MISSING FROM CLAIM
779	CONSUMER CONTRIBUTION IS LESS THAN OR GREATER THAN 72% OF ANNUAL MAX SUPPLEMENTAL SECURITY INCOME (SSI)
780	INELIGIBLE (UNLICENSED) RESIDENTIAL SERVICES

781	ELIGIBLE (UNLICENSED) RESIDENTIAL SERVICES
782	CANNOT SPAN A CALENDAR WEEK
783	SERVICE PROGRAM FLIPPED TO WAVER 14 DUE TO 'ET' MODIFIER ON THE CLAIM
784	'ET' MODIFIER INDICATED ON CLAIM
785	NOT ALLOWED TO BILL FOR EMERGENCY SERVICE
786	CANNOT SPAN DATE
787	COUNTY CODE ON CLAIM DOES NOT MATCH THE PLAN
788	EIX RECORD MISSING FOR RECEPIENT
789	PERMANENT VACANCY WAVER 12 SELECTED
790	OBSERVATION PAYMENTS REQUIRE MINIMUM OF EIGHT HRS OF SERVICE
791	OBSERVATION: EIGHT TO 48 HOURS REPORTED
792	MORE THAN 48 HOURS OF OBSERVATION SERVIVES BILLED
793	OBSERVATION EQUAL OR GREATER THAN 24 HOURS AND SINGLE DATE OF SERVICE REPORTED
794	OBSERVATION GREATER THAN 24 HOURS SPANNING TWO DAYS
795	OBSERVATION LESS THAN 24 HOURS AND GREATER THAN TWO DAYS REPORTED
796	OBSERVATION GREATER THAN 24 HOURS & LESS THAN 48 HOURS AND GREATER THAN THREE DAYS REPORTED
797	OBSERVATION GREATER THAN 48 HOURS AND GREATER THAN THREE DAYS REPORTED
798	HEADER/DETAIL DATES OF SERVICE CONFLICT
799	CONDITION CODE 44: OUTPATIENT OBSERVATION ONLY
800	MEDICARE ADVANTAGE CLAIM
801	INPATIENT MEDICARE ADVANTAGE DEDUCTIBLE
802	INPATIENT MEDICARE ADVANTAGE COINSURANCE
803	PROFESSIONAL / OUTPATIENT MEDICARE ADVANTAGE DEDUCTIBLE
804	PROFESSIONAL / OUTPATIENT MEDICARE ADVANTAGE COINSURANCE
805	MEDICARE ADVANTAGE - ALL DEDUCTIBLE
806	MEDICARE ADVANTAGE QUALIFIED MEDICARE BENEFICIARY (QMB)
807	MEDICARE ADVANTAGE QUALIFIED MEDICARE BENEFICIARY (QMB) NON-COVERED SERVICES (NCS) ALLOWED AMOUNT LESS THAN $1,000
808	MEDICARE ADVANTAGE QUALIFIED MEDICARE BENEFICIARY (QMB) NON-COVERED SERVICES (NCS) ALLOWED AMOUNT GREATER THAN OR EQUAL TO $1,000
809	QUALIFIED MEDICARE BENEFICIARY (QMB) NON-COVERED SERVICE
810	NO PAYMENT DUE FOR MEDICARE ADVANTAGE COST SHARING
811	MEDICARE ADVANTAGE COST SHARING AMOUNTS EXCEED BILLED AMOUNT
812	INPATIENT CLAIM - CLAIM ADJUSTMENT REASON CODE 3
813	MEDICARE ADVANTAGE CLAIMS REQUIRE MEDICARE A & B COVERAGE
814	MEDICARE ADVANTAGE INPATIENT CLAIMS REQUIRE MEDICARE A & B COVERAGE
815	PROVIDER PREVENTABLE CONDITION MANUAL REVIEW REQUIRED
816	OPPC (OTHER PROVIDER PREVENTABLE CONDITIONS) INPATIENT/LONG TERM CARE (LTC) SETTING-MANUALLY REVIEW ATTACHMENT

817	OPPC (OTHER PROVIDER PREVENTABLE CONDITIONS) E or Y DIAGNOSIS CODE IN ADMITTING DIAGNOSIS FIELD
818	HEALTHCARE ACQUIRED CONDITION (HAC)
819	CLAIM ADJUSTMENT REASON CODES (CARC) 233 REPORTED
820	PRIMARY DIAGNOSIS POA (PRESENT ON ADDMISSION) INDICATOR W OR U
821	BLOOD INCOMPATIBILITY REPORTED ON CLAIM
822	HEALTHCARE ACQUIRED CONDITION (HAC) FALLS AND TRAUMA
823	DIAGNOSIS IS NOT POA (PRESENT ON ADDMISSION) EXEMPT
824	POA (PRESENT ON ADDMISSION) INDICATOR 1 MAY ONLY BE USED ON UB04 (PAPER)
825	INPATIENT ACUTE CARE OPPC (OTHER PROVIDER PREVENTABLE CONDITIONS) - ALL PATIENT REFINED-DIAGNOSIS RELATED GROUP (APR/DRG)
826	DETAIL SPANS CALENDAR YEAR/SPLIT DETAIL FOR PAYMENT
827	PROGRAM EXCEPTION (PE) AUTHORIZATION FEE IS LESS THAN ACA (AFFORDABLE CARE ACT OF 2010) PRIMARY CARE SERVICES (PCS) RATE FOR PRIMARY CARE PROVIDER (PCP)
828	ACA (AFFORDABLE CARE ACT OF 2010) PROCEDURE CODING SYSTEM (PCS) UNASSIGNED HEALTHCARE BENEFITS PACKAGE
829	SEQUESTRATION CLAIM ADJUSTMENT REASON CODES (CARC) REQUIRED DATE OF SERVICE ON OR AFTER 4/1/2013
830	SEQUESTRATION CLAIM ADJUSTMENT REASON CODES (CARC) REPORTED ON THE CLAIM LINE
831	MULTIPLE SEQUESTRATION CLAIM ADJUSTMENT REASON CODES (CARC) REPORTED ON CLAIM LINE
832	SEQUESTRATION CLAIM ADJUSTMENT REASON CODES (CARC) AMOUNT MAY NOT BE $0 (ZERO)
833	SAME SEQUESTRATION CLAIM ADJUSTMENT REASON CODES (CARC) USED MORE THAN ONE TIME ON CLAIM LINE
834	MEDICARE B DEDUCTIBLE ONLY: DETAIL CONTAINS SEQUESTRATION CLAIM ADJUSTMENT REASON CODES (CARC)
836	PAYER IDENTIFICATION CODE EXCEEDS 80 - HEADER
837	PAYER IDENTIFICATION CODE EXCEEDS 80 - DETAIL
840	THE PATIENT PAY AMOUNT IS MISSING OR INVALID FOR THIS SERVICE ON A NATIONAL COUNCIL OF PRESCRIPTION DRUG PROGRAM (NCPDP) TRANSACTION
841	PREVENTABLE SERIOUS ADVERSE EVENTS (PSAE) REVIEW
842	TOTAL BILLED AMOUNT MISSING FOR CHC (Community Health Choices) WAIVER SERVICE
843	NO OFFICE OF LONG TERM LIVING (OLTL) - CHC (Community Health Choices) REGIONAL RATE FOUND
844	NO OFFICE OF LONG TERM LIVING (OLTL) - CHC (Community Health Choices) STATEWIDE RATE FOUND
845	ONLY A MANAGED CARE ORGANIZATION (MCO) CAN SUBMIT ENCOUNTER CLAIMS
846	WHEN THE RENDERING PROVIDER IDENTIFICATION IS BILLED AS ALL EIGHT'S THEN THE SERVICE PROVIDER QUALIFIER FIELD MUST EQUAL 99
847	THIS RECIPIENT IS ENROLLED WITH ANOTHER MANAGED CARE ORGANIZATION (MCO) ON THE DATE(S) OF SERVICE INDICATED - DETAIL
848	RECIPIENT IS IN ANOTHER MANAGED CARE ORGANIZATION (MCO) ON THE DATE OF SERVICE - HEADER
868	EXACT DUPLICATE PAID / CAPTURED CLAIM
869	GENERIC DUPLICATE PAID / CAPTURED CLAIM
871	DRUG UTILIZATION REVIEW (DUR) CANCELLATION / OVERRIDE - CANNOT BE LOCATED OR MUST BE SENT WITHIN 72 HOURS
900	THE SERVICE PROGRAM DOES NOT EXIST

901	THE SERVICE PROGRAM FOR THIS RECIPIENT AND CLAIM IS MISSING FROM THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
902	RECIPIENT IDENTIFICATION MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
903	PROVIDER IDENTIFICATION IS MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
904	PROCEDURE CODE IS MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
905	BEGIN DATE OF SERVICE MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
906	END DATE OF SERVICE MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
907	PROVIDER SERVICE LOCATION MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
908	UNITS MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
909	AMOUNT BILLED MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
910	INTERNAL CONTROL NUMBER (ICN) MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
911	INTERNAL ERROR
912	INTERNAL CONTROL NUMBER (ICN) LINE NUMBER MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
913	INVALID TRANSACTION INDICATOR
914	PREVIOUS INTERNAL CONTROL NUMBER (ICN) MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
915	PREVIOUS INTERNAL CONTROL NUMBER (ICN) LINE MISSING IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
916	INVALID SOCIAL SECURITY NUMBER (SSN) FOR THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) TRANSACTION
917	ORIGINAL NON-MEDICAL RENDERING SOCIAL SECURITY NUMBER (SSN) DOES NOT MATCH ADJUDICATED NON-MEDICAL SOCIAL SECURITY NUMBER (SSN)
918	PROCEDURE CODE NOT VALID FOR WAIVER RECIPIENT
919	PARTICIPANT DIRECTED SERVICES (PDS) AUTHORIZED SERVICE NOT FOUND ON INDIVIDUAL SUPPORT PLAN (ISP)
920	PARENTS DECLINE MEDICAL ASSISTANCE BILLING
921	UNIT REDUCED AS PER AVAILABLE ON PLAN
922	NO PHARMACY GROUP FOUND
950	RECIPIENT IDENTIFICATION INVALID IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS), NO AUTHORIZED SERVICES ARE FOUND IN HCSIS FOR MCI NBR.
951	PROCEDURE CODE INVALID IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
952	BEGIN DATE OF SERVICE INVALID IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
953	END DATES OF SERVICE INVALID IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
954	PROVIDER ID INVALID IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
955	PROVIDER SERVICE LOCATION INVALID IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
956	RECIPIENT NOT ENROLLED IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) PROGRAM
957	THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) SERVICE PROGRAM DISAGREES WITH THE PROMISE SERVICE PROGRAM
958	BILLED AMOUNT IS NOT EQUAL TO THE CONTRACT RATE

959	INTERNAL CONTROL NUMBER (ICN) NOT FOUND IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
960	INTERNAL CONTROL NUMBER (ICN) LINE NUMBER NOT FOUND IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
961	PREVIOUS INTERNAL CONTROL NUMBER (ICN) NOT FOUND IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
962	PREVIOUS INTERNAL CONTROL NUMBER (ICN) LINE NUMBER NOT FOUND IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
963	DIRECT CARE PROVIDER IS NOT VALID FOR THIS SERVICE
964	COUNTY NOT ENROLLED IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
965	SERVICE COVERED UNDER MORE THAN ONE PLAN - DETAIL PAYABLE UNDER MULTIPLE PLAN SERVICES
966	RATE APPROVED LESS THAN BILLED
967	UNITS APPROVED LESS THAN BILLED
968	THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) AND PROMISE SERVICE PROGRAM DO NOT MATCH FOR THE OFFICE OF DEVELOPMENTAL PROGRAMS (ODP) / EARLY INTERVENTION SERVICES BILLED
969	THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) / PROMISE SERVICE PROGRAM CHANGE
970	PROCEDURE PRICED USING THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) FEE SCHEDULE
971	SERVICE INDICATED, BUT NO UNITS AVAILABLE IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
972	BILLABLE SERVICE NOTE DOES NOT EXIST IN THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
975	CLAIM EXCEEDS THE OFFICE OF DEVELOPMENTAL PROGRAMS (ODP) TIMELY FILING LIMIT
976	A VALID PRIOR AUTHORIZATION REJECTION IS NOT ON FILE FOR WAIVER SERVICES INDICATED
977	PRIOR AUTHORIZATION (PA) MISSING FOR WAIVER SERVICES
978	PRIOR AUTHORIZATION (PA) EXHAUSTED FOR WAIVER SERVICES
979	PRIOR AUTHORIZATION (PA) DENIED FOR WAIVER SERVICES
980	ALL PATIENT REFINED-DIAGNOSIS RELATED GROUP (APR/DRG) GROUPER ERROR
981	HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) WEB SERVICE ERROR
982	ADMISSION DATE IS PRIOR TO THE BABY'S DATE OF BIRTH
998	THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS) IS UNAVAILABLE
999	CLIENT INFORMATION SYSTEM (CIS) UNAVAILABLE
1000	BILLING PROVIDER IDENTIFICATION IS NOT ON FILE
1001	THE BILLING PROVIDER IS NOT ENROLLED AT THE SERVICE LOCATION FOR THE PROGRAM BILLED
1002	RENDERING PROVIDER IS NOT ELIGIBLE TO PERFORM SERVICES IN THIS PROGRAM
1003	BILLING PROVIDER IS NOT ENROLLED AT SERVICE LOCATION FOR THE CLAIM DATES OF SERVICE BILLED
1006	UNABLE TO ASSIGN A MEDICAID PROVIDER IDENTIFICATION FOR RENDERING PROVIDER
1007	RENDERING PROVIDER IS NOT ON PROVIDER DATABASE
1008	RENDERING PROVIDER MUST HAVE AN INDIVIDUAL PROVIDER IDENTIFICATION NUMBER
1009	THE CLAIM RENDERING PROVIDER IS NOT ON FILE - RENDERING PROVIDER NOT ON PROVIDER DATABASE
1010	CLAIM DETAIL RENDERING PROVIDER IS NOT A MEMBER OF THE PROVIDER GROUP OR THE RENDERING PROVIDER IDENTIFICATION IS NOT EQUAL TO THE BILLING PROVIDER
1011	CLAIM RENDERING PROVIDER IS NOT A MEMBER OF THE PROVIDER GROUP OR THE RENDERING PROVIDER IDENTIFICATION IS NOT EQUAL TO THE CLAIM BILLING PROVIDER IDENTIFICATION

1012	RENDERING PROVIDER SPECIALTY NOT ELIGIBLE TO RENDER PROCEDURE CODE
1013	INVALID RELATIONSHIP BETWEEN BILLING AND RENDERING PROVIDER
1014	CLAIM DETAIL RENDERING PROVIDER IDENTIFICATION HAS A CHECK DIGIT ERROR
1015	DRUG ENFORCEMENT AGENCY (DEA) NUMBER INDICATED IS NOT ON FILE - CONTACT PROVIDER ENROLLMENT AT (717) 772-6456.
1016	RENDERING PROVIDER CHECK DIGIT ERROR - HEADER
1017	FINAL DIGIT OF GROUP IDENTIFICATION DOES NOT MATCH THE ONE CALCULATION
1018	A VALID ACTIVE RATE SEGMENT IS NOT ON FILE FOR THE LEVEL OF CARE INDICATED. CHECK YOUR PROVIDER NUMBER AND MAKE SURE YOU ARE USING THE CORRECT NUMBER.
1019	INVALID RELATIONSHIP BETWEEN THE BILLING AND RENDERING PROVIDER
1020	PEP VALIDATION (ESC 1002/1003) BYPASS
1021	OPERATING PHYSICIAN IDENTIFICATION NUMBER IS NOT ON FILE - DETAIL
1022	OTHER PHYSICIAN IDENTIFICATION NUMBER IS NOT ON FILE - DETAIL
1023	OPERATING PHYSICIAN IDENTIFICATION NUMBER IS NOT ON FILE - HEADER
1024	OTHER PHYSICIAN IDENTIFICATION NUMBER IS NOT ON FILE - HEADER
1025	PRESCRIBING NATIONAL PROVIDER IDENTIFIER (NPI) OR LICENSE NUMBER IS INVALID
1026	PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE
1027	REFERRING PHYSICIAN IDENTIFICATION NUMBER BILLED IS NOT ON FILE
1028	TYPE OF BILL CODE INVALID FOR PROVIDER TYPE / SPECIALTY
1029	LICENSE IS IN A VALID FORMAT
1030	PRESCRIBER LICENSE NUMBER BILLED ON THE CLAIM - NATIONAL PROVIDER IDENTIFIER (NPI) REQUIRED
1032	BILLING PROVIDER IS NOT ELIGIBLE TO BILL THIS CLAIM TYPE
1033	PRESCRIBER INFORMATION REQUIRED, PRESCRIBER NATIONAL PROVIDER IDENTIFIER (NPI) NOT FOUND
1034	INVALID PRESCRIBER STATE ADDRESS CODE
1036	RENDERING PROVIDER BILLED IS NOT ELIGIBLE TO PERFORM SERVICES FOR THIS CLAIM TYPE
1037	PRESCRIBER ENROLLED, NO SERVICE LOCATION ACTIVE FOR DATE OF SERVICE
1038	PRESCRIBER ENROLLED, NO SERVICE LOCATION ACTIVE EMERGCY SERVICE
1048	PROVIDER INDICATED IS SUSPENDED OR TERMINATED AND NOT ELIGIBLE TO PERFORM SERVICES
1050	SPECIALTY ENROLLMENT REQUIRED FOR TOPICAL FLUORIDE VARNISH
1051	CLAIM DETAIL RENDERING PROVIDER IDENTIFICATION / SERVICE LOCATION COMBINATION IS NOT ON FILE
1052	RENDERING PROVIDER IDENTIFICATION / SERVICE LOCATION COMBINATION NOT ON FILE - HEADER
1053	BOARD CERTIFICATION AND/OR VOLUME CERTIFICATION REQUIRED FOR ACA (AFFORDABLE CARE ACT) FEE
1054	ATTENDANT CARE WAIVER SERVICES MUST BE BILLED IN 14 DAY INCREMENTS
1055	SPAN DATES: SPLIT DETAIL DATES BY BOARD/VOLUME CERTIFICATION
1056	RENDERING MEDICARE IDENTIFICATION IS NOT ON FILE - HEADER
1057	RENDERING MEDICARE IDENTIFICATION IS NOT ON FILE - DETAIL
1058	MEDICARE PROVIDER IDENTIFICATION INDICATED IS NOT ON FILE
1060	YOUR PROVIDER TYPE REQUIRES A MEDICARE APPROVED AMOUNT

1061	THE CLAIM SUBMITTED FAILED TO CONTAIN THE APPROPRIATE PAYEE INFORMATION
1062	THE INVOICE INDICATES THAT THE RECIPIENT WAS HOSPITALIZED BUT THE FACILITY MEDICAL ASSISTANCE (MA) IDENTIFICATION NUMBER IS MISSING
1064	FACILITY IDENTIFICATION PRESENT AND NUMERIC; HOWEVER NOT A VALID VALUE ON THE PROVIDER FILE OR THE PROVIDER TYPE AND SPECIALTY IS NOT 01/21, 02/20, 01/10, 01/16, 01/17, 01/12, 01/19, 01/11, 01/22, OR 01/23.
1065	PROVIDER ENROLLED AS A BULK IMMUNIZATION PROVIDER AND IS BILLING FOR AN NATIONAL DRUG CODE (NDC) THAT IS SUPPLIED BY THE DEPARTMENT OF HEALTH
1066	PROVIDER IS NOT A MAMMOGRAPHY QUALITY STANDARDS ACT (MQSA) CERTIFIED PROVIDER.
1067	CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) BILLING OR PRESCRIBING FOR CONTROLLED DRUGS AND THE DAYS SUPPLY EXCEEDS THE MAXIMUM LIMIT
1068	"HAD" INDICATOR NOT VALID FOR RENDERING PROVIDER
1069	SPECIAL INDICATOR "OGT" REQUIRED FOR MATERNAL FETAL TELE-CONSULTATION
1070	PRESCRIBER NOT LINKED TO A FAMILY PLANNING CLINIC
1071	THE IDENTIFICATION FOR THE BILLING PROVIDER HAS BEEN LOCATED ON THE PRECLUDED PROVIDER LIST. THAT PROVIDER IS NOT ELIGIBLE TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM FOR THE REPORTED DATE OF SERVICE.
1072	THE IDENTIFICATION FOR THE RENDERING PROVIDER HAS BEEN LOCATED ON THE PRECLUDED PROVIDER LIST. THAT PROVIDER IS NOT ELIGIBLE TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM FOR THE REPORTED DATE OF SERVICE.
1073	THE IDENTIFICATION FOR THE REFERRING PROVIDER HAS BEEN LOCATED ON THE PRECLUDED PROVIDER LIST. THAT PROVIDER IS NOT ELIGIBLE TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM FOR THE REPORTED DATE OF SERVICE.
1074	THE IDENTIFICATION FOR THE ATTENDING PROVIDER HAS BEEN LOCATED ON THE PRECLUDED PROVIDER LIST. THAT PROVIDER IS NOT ELIGIBLE TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM FOR THE REPORTED DATE OF SERVICE.
1075	THE IDENTIFICATION FOR THE PRESCRIBING PROVIDER HAS BEEN LOCATED ON THE PRECLUDED PROVIDER LIST. THAT PROVIDER IS NOT ELIGIBLE TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM FOR THE REPORTED DATE OF SERVICE.
1076	THE IDENTIFICATION FOR THE FIRST OTHER PROVIDER HAS BEEN LOCATED ON THE PRECLUDED PROVIDER LIST. THAT PROVIDER IS NOT ELIGIBLE TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM FOR THE REPORTED DATE OF SERVICE.
1077	THE IDENTIFICATION FOR THE SECOND OTHER PROVIDER HAS BEEN LOCATED ON THE PRECLUDED PROVIDER LIST. THAT PROVIDER IS NOT ELIGIBLE TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM FOR THE REPORTED DATE OF SERVICE.
1078	THE IDENTIFICATION FOR THE FACILITY PROVIDER HAS BEEN LOCATED ON THE PRECLUDED PROVIDER LIST. THAT PROVIDER IS NOT ELIGIBLE TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM FOR THE REPORTED DATE OF SERVICE.
1079	RENDERING PRECLUDED PROVIDER - PROFESSIONAL
1080	REFERRING PRECLUDED PROVIDER - PROFESSIONAL
1081	LOCK IN BYPASS BILLED FROM SPECIALTY PROVIDER
1082	THIRD PARTY LIABILITY (TPL) BYPASS OF SPECIALTY PROVIDER
1083	VERIFY THIRD PARTY LIABILITY (TPL) AMOUNT FOR SPECIALTY DRUG
1084	EMERGENCY SUPPLY OF SPECIALTY DRUG FROM NON-PARTICIPATING PROVIDER
1085	DRUG MUST BE BILLED FROM A SPECIALTY PROVIDER
1086	MISSING STATUS FOR SPECIALTY GENERIC CODE NUMBER (GCN) SEQUENCE NUMBER
1087	SPECIALTY BRAND DRUG - USE GENERIC
1088	ONLY SPECIALTY PHARMACIES MAY BILL 'S' CODES
1089	SPECIALTY PHARMACY BYPASS FOR COUNTY CODE
1090	CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) LIMITED TO 30 DAY SUPPLY OF CII

1091	CNM PRESCRIBING FOR REFILL OF C3-4 DRUG
1092	TYPE OF BILL INVALID FOR ENCOUNTER 837I DRUG CLAIM
1093	INVALID COUPON TYPE SUBMITTED
1100	THE NATIONAL PROVIDER IDENTIFIER (NPI) REPORTED FOR THE BILLING PROVIDER WAS NOT FOUND
1101	MULTIPLE BILLING NATIONAL PROVIDER IDENTIFIER (NPI), NO MATCH TAXONOMY, NO MATCH WITH ZIP CODE
1102	MULTIPLE BILLING NATIONAL PROVIDER IDENTIFIER (NPI)/TAXONOMY NO MATCH WITH ZIP CODE
1103	MULTIPLE SERVICE LOCATION FOR BILLING NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1104	THE NATIONAL PROVIDER IDENTIFIER (NPI) REPORTED FOR THE RENDERING PROVIDER WAS NOT FOUND
1105	MULTIPLE RENDERING NATIONAL PROVIDER IDENTIFIER (NPI), NO MATCH TAXONOMY MATCH WITH ZIP CODE
1106	MULTIPLE RENDERING NATIONAL PROVIDER IDENTIFIER (NPI)/TAXONOMY, NO MATCH WITH ZIP CODE
1107	MULTIPLE RENDERING NATIONAL PROVIDER IDENTIFIER (NPI), TAXONOMY NOT FOUND
1108	MULTIPLE TAXONOMY NO SERVICE LOCATION MATCH
1109	MULTIPLE SERVICE LOCATION FOR RENDERING NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1110	THE NATIONAL PROVIDER IDENTIFIER (NPI) REPORTED FOR THE REFERRING PROVIDER WAS NOT FOUND
1111	MULTIPLE SERVICE LOCATION FOR REFERING NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1112	MULTIPLE SERVICE LOCATION FOR REFERING NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1113	THE NATIONAL PROVIDER IDENTIFIER (NPI) REPORTED FOR THE ATTENDING PROVIDER WAS NOT FOUND
1114	MULTIPLE SERVICE LOCATION FOR ATTENDING NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1115	MULTIPLE SERVICE LOCATION FOR ATTENDING NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1116	THE NATIONAL PROVIDER IDENTIFIER (NPI) FOR THE FIRST OTHER PROVIDER WAS NOT FOUND
1117	MULTIPLE SERVICE LOCATION FOR THE FIRST OTHER NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1118	MULTIPLE SERVICE LOCATION FOR THE FIRST OTHER NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1119	THE NATIONAL PROVIDER IDENTIFIER (NPI) FOR THE SECOND OTHER PROVIDER WAS NOT FOUND
1120	MULTIPLE SERVICE LOCATION FOR THE SECOUND OTHER NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1121	MULTIPLE SERVICE LOCATION FOR THE SECOUND OTHER NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1122	MULTIPLE SERVICE LOCATION FOR THE PRESCRIBING NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED.
1123	THE NATIONAL PROVIDER IDENTIFIER (NPI) REPORTED FOR THE FACILITY PROVIDER WAS NOT FOUND
1124	MULTIPLE SERVICE LOCATION FOR FACILITY NATIONAL PROVIDER IDENTIFIER (NPI) TAX - DEFAULT USED.
1125	MULTIPLE MATCH NATIONAL PROVIDER IDENTIFIER (NPI), NO MATCH NATIONAL PROVIDER IDENTIFIER (NPI) AND ZIP CODE
1126	BILLING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NOT VALIDATED
1127	BILLING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) IS NOT AVAILABLE FOR USE (MARKED AS FRAUDULENT)
1128	RENDERING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NOT VALIDATED
1129	RENDERING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) IS NOT AVAILABLE FOR USE (MARKED AS FRAUDULENT)
1130	RENDERING PROVIDER IS A HEALTHCARE PROVIDER AND A LEGACY IDENTIFICATION WAS SUBMITTED ON THE CLAIM.
1131	BILLING PROVIDER IS HLTHCARE BUT NO NATIONAL PROVIDER IDENTIFIER (NPI) ON FILE AT THE DEPARTMENT OF HUMAN SERVICES (DHS)
1132	RENDERING PROVIDER IS HEALTHCARE BUT NO NATIONAL PROVIDER IDENTIFIER (NPI) ON FILE AT THE DEPARTMENT OF HUMAN SERVICES (DHS)

1133	THE BILLING SERVICE LOCATION IS MISSING MEDICARE PAYMENT INDICATOR
1134	THE RENDERING SERVICE LOCATION IS MISSING MEDICARE PAYMENT INDICATOR
1135	THE BILLING NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS INVALID.
1136	THE RENDERING NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS INVALID.
1137	THE REFERRING NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS INVALID.
1138	THE ATTENDING NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS INVALID.
1139	THE PRESCRIBING NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS INVALID.
1140	THE FIRST OTHER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS INVALID.
1141	THE SECOND OTHER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS INVALID.
1142	ADJUSTMENT CLAIM WAS BILLED WITH A BILLING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER AND SUCCESSFULLY CROSS WALKED TO THE LEGACY NUMBER ON THE ORIGINAL CLAIM.
1143	PRESCRIBER NATIONAL PROVIDER IDENTIFIER (NPI) ON CLAIM NOT FOUND.
1144	A LICENSE NUMBER COULD NOT BE ASSIGNED FOR THE PRESCRIBING PROVIDER'S NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER.
1145	THE BILLING PROVIDER'S SOCIAL SECURITY NUMBER (SSN) / FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) SUBMITTED ON THE CLAIM FORM DOES NOT MATCH THE SOCIAL SECURITY NUMBER/FEIN ON THE PROVIDER FILE FOR THE SERVICE LOCATION.
1146	THE RENDERING PROVIDER'S SOCIAL SECURITY NUMBER (SSN) / FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) SUBMITTED ON THE CLAIM FORM DOES NOT MATCH THE SOCIAL SECURITY NUMBER (SSN) / FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN) ON THE PROVIDER FILE FOR THE SERVICE LOCATION.
1147	THE TAXONOMY CODE SUBMITTED ON THE CLAIM FORM FOR THE BILLING PROVIDER IS NOT REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES.
1148	THIS ESC IS NOT BEING USED
1149	THE TAXONOMY CODE SUBMITTED ON THE CLAIM FORM FOR THE RENDERING PROVIDER IS NOT REGISTERED WITH THE DEPARTMENT OF HUMAN SERVICES.
1150	THE BILLING PROVIDER IS REGISTERED AS A HEALTHCARE PROVIDER ON THE DEPARTMENT OF HUMAN SERVICES (DHS) PROVIDER FILE AND SHOULD BE SUBMITTING WITH A NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER NOT A LEGACY IDENTIFICATION.
1151	ADJUSTMENT CLAIM WAS SUBMITTED WITH RENDERING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) MATCHES THE LEGACY NUMBER ON THE ORIGINAL CLAIM.
1152	QUALIFIER INDICATES THAT THE BILLING PROVIDER'S NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER WAS SUBMITTED; HOWEVER, AN INCORRECT FORMAT FOR A VALID NATIONAL PROVIDER IDENTIFIER (NPI) WAS USED.
1153	QUALIFIER INDICATES THAT THE BILLING PROVIDER'S LEGACY NUMBER WAS SUBMITTED; HOWEVER, AN INCORRECT FORMAT FOR A LEGACY NUMBER WAS USED.
1154	QUALIFIER INDICATES THAT THE PRESCRIBING PROVIDER'S NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER WAS SUBMITTED; HOWEVER, AN INCORRECT FORMAT FOR A VALID NATIONAL PROVIDER IDENTIFIER (NPI) WAS USED.
1155	QUALIFIER INDICATES THAT THE PRESCRIBING PROVIDER'S LEGACY NUMBER WAS SUBMITTED; HOWEVER, AN INCORRECT FORMAT FOR A VALID LEGACY NUMBER WAS USED.
1156	QUALIFIER INDICATES THAT THE PRESCRIBING PROVIDER'S LICENSE NUMBER WAS SUBMITTED; HOWEVER, AN INCORRECT FORMAT FOR A VALID LICENSE NUMBER WAS USED.
1157	THE FACILITY NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS INVALID.
1158	THE CLAIM WAS SUBMITTED WITH BOTH THE BILLING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER AND THE LEGACY NUMBER. THE BILLING PROVIDER NPI NUMBER, SUBMITTED ON THE CLAIM, DOES NOT MATCH THE BILLING PROVIDER LEGACY NUMBER SUBMITTED ON THE CLAIM. THE NPI NUMBER WAS USED TO PROCESS THE CLAIM

1159	THE CLAIM WAS SUBMITTED WITH BOTH THE RENDERING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER AND THE LEGACY NUMBER. THE RENDERING PROVIDER NPI NUMBER, SUBMITTED ON THE CLAIM, DOES NOT MATCH THE RENDERING PROVIDER LEGACY NUMBER SUBMITTED ON THE CLAIM. THE NPI NUMBER WAS USED TO PROCESS THE CLAIM
1160	THE CLAIM WAS SUBMITTED WITH BOTH THE BILLING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER AND THE LEGACY NUMBER. THE BILLING PROVIDER NPI NUMBER, SUBMITTED ON THE CLAIM, DOES NOT MATCH THE BILLING PROVIDER LEGACY NUMBER SUBMITTED ON THE CLAIM. THE LEGACY NUMBER WAS USED TO PROCESS THE CLAIM
1161	THE CLAIM WAS SUBMITTED WITH BOTH THE RENDERING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER AND THE LEGACY NUMBER. THE RENDERING PROVIDER NPI NUMBER, SUBMITTED ON THE CLAIM, DOES NOT MATCH THE RENDERING PROVIDER LEGACY NUMBER SUBMITTED ON THE CLAIM. THE LEGACY NUMBER WAS USED TO POCESS THE CLAIM
1162	THE CLAIM WAS SUBMITTED WITH BOTH THE BILLING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER AND THE LEGACY NUMBER. THE BILLING PROVIDER NPI NUMBER COULD NOT BE CROSS WALKED TO THE BILLING PROVIDER LEGACY NUMBER. THE LEGACY NUMBER WAS USED TO PROCESS THE CLAIM
1163	THE CLAIM WAS SUBMITTED WITH BOTH THE RENDERING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER AND THE LEGACY NUMBER. THE RENDERING PROVIDER NPI NUMBER COULD NOT BE CROSS WALKED TO THE RENDERING LEGACY NUMBER. THE LEGACY NUMBER WAS USED TO PROCESS THE CLAIM
1164	THE FIRST OTHER PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS NOT AVAILABLE FOR USE.
1165	THE SECOND OTHER PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS NOT AVAILABLE FOR USE.
1166	THE ATTENDING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS NOT AVAILABLE FOR USE.
1167	THE REFERRING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS NOT AVAILABLE FOR USE.
1168	THE FACILITY PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS NOT AVAILABLE FOR USE.
1169	THE PRESCRIBING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUBMITTED IS NOT AVAILABLE FOR USE.
1170	THE PROVIDER'S NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER SUCCESSFULLY CROSS WALKED, BUT THERE ARE MULTIPLE SERVICE LOCATIONS THAT HAVE A MEDICARE INDICATOR.
1171	LICENSE & NATIONAL PROVIDER IDENTIFIER (NPI) - ATTENDING LICENSE USED TO PROCESS THE CLAIM
1172	LICENSE & NATIONAL PROVIDER IDENTIFIER (NPI) - OPERATING LICENSE USED TO PROCESS THE CLAIM
1173	LEGACY IDENTIFICATION & NATIONAL PROVIDER IDENTIFIER (NPI) - OTHER PHYSICIAN LEGACY USED TO PROCESS THE CLAIM
1174	LEGACY & NATIONAL PROVIDER IDENTIFIER (NPI) - REFERRING LEGACY USED TO PROCESS THE CLAIM
1175	LEGACY & NATIONAL PROVIDER IDENTIFIER (NPI) - FACILITY LEGACY USED TO PROCESS THE CLAIM
1176	MULTIPLE SERVICE LOCATION FOR RENDERING NATIONAL PROVIDER IDENTIFIER (NPI) - NO HEALTHY BEGINNING PLUS (HBP) - DEFAULT USED
1177	SERVICE LOCATION WITH HEALTHY BEGINNINGS PLUS (HBP) FOR RENDERING NATIONAL PROVIDER IDENTIFIER (NPI)
1178	REFERRING PROVIDER IDENTIFIED AS HEALTHCARE, NATIONAL PROVIDER IDENTIFIER (NPI) REQUIRED
1179	ATTENDING PROVIDER IDENTIFIED AS HEALTHCARE, NATIONAL PROVIDER IDENTIFIER (NPI) REQUIRED
1180	OPERATING PROVIDER IDENTIFIED AS HEALTHCARE, NATIONAL PROVIDER IDENTIFIER (NPI) REQUIRED
1181	FACILITY PROVIDER IDENTIFIED AS HEALTHCARE, NATIONAL PROVIDER IDENTIFIER (NPI) REQUIRED
1183	SECOUND OTHER PROVIDER IDENTIFIED AS HEALTHCARE, NATIONAL PROVIDER IDENTIFIER (NPI) REQUIRED
1184	BILLING NATIONAL PROVIDER IDENTIFIER (NPI) DATE RANGE IS NOT WITHIN THE DATE OF SERVICE (DOS)
1185	PRESCRIBER NATIONAL PROVIDER IDENTIFIER (NPI) DATE RANGE NOT WITHIN THE DATE OF SERVICE (DOS)
1186	RENDERING NATIONAL PROVIDER IDENTIFIER (NPI) DATE RANGE NOT WITHIN THE DATE OF SERVICE (DOS)
1187	REFERRING CONTAINS NATIONAL PROVIDER IDENTIFIER (NPI) AND 9 OR 13 DIGIT LEGACY IDENTIFICATION

1188	NATIONAL PROVIDER IDENTIFIER (NPI) AND 9 OR 13 DIGIT IDENTIFICATION IN OTHER PHYSICIAN
1189	NO MATCH ON BILLING PROVIDER ON ADJUSTMENT
1190	NO MATCH ON RENDERING PROVIDER
1191	NATIONAL PROVIDER IDENTIFIER (NPI) & LEGACY SUBMITTED IN REFERRING ID FIELD
1192	NATIONAL PROVIDER IDENTIFIER (NPI) & LEGACY SUBMITTED IN OTHER PHYSICIAN ON UNIFIED BILLING (UB)
1194	NATIONAL PROVIDER IDENTIFIER (NPI)/LEGACY ADJUSTMENT MANUAL REVIEW
1195	PRESCRIBER NATIONAL PROVIDER IDENTIFIER (NPI) SUBMITTED IS ACTIVE NPPES (National Plan & Provider Enumeration System) PHARMACY NATIONAL PROVIDER IDENTIFIER (NPI)
1196	PRESCRIBER NATIONAL PROVIDER IDENTIFIER (NPI) SUBMITTED IS INACTIVE NPPES (National Plan & Provider Enumeration System) PHARMACY NATIONAL PROVIDER IDENTIFIER (NPI)
1197	PRESCRIBER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER NPPES (National Plan & Provider Enumeration System) ACTIVE NOT MA (Medical Assistance) ENROLLED FOR DATE OF SERVICE
1198	EMERGENCY SERVICE FOR PRESCRIBER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER ACTIVE IN NPPES (National Plan & Provider Enumeration System)
1200	CLAIM PROCESSED DURING PANDEMIC EXCEPTION PERIOD
1201	CLAIM LINE DOES NOT CONTAIN MEDICARE INFORMATION
1202	HEADER/DETAIL MEDICARE COINSURANCE AMOUNTS DO NOT BALANCE
1203	HEADER/DETAIL MEDICARE DEDUCTIBLE AMOUNTS DO NOT BALANCE
1204	HEADER/DETAIL MEDICARE PAID AMOUNTS DO NOT BALANCE
1205	HEADER/DETAIL MEDICARE APPROVED AMOUNTS DO NOT BALANCE
1206	HEADER/DETAIL THIRD PARTY PAID AMOUNTS DO NOT BALANCE
1207	HEADER/DETAIL THIRD PARTY DEDUCTIBLE AMOUNTS DO NOT BALANCE
1208	HEADER/DETAIL THIRD PARTY COINSURANCE / COPAY AMOUNTS DO NOT BALANCE
1209	VALUE CODE 06 MAY NOT BE USED ON ELECTRONIC CLAIMS
1210	REPORTED BILLING NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER IS INVALID
1211	BILLING NATIONAL PROVIDER IDENTIFIER (NPI) NOT REPORTED ON PAPER/INTERNET CLAIM
1212	REPORTED RENDERING NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER IS INVALID
1213	RENDERING NATIONAL PROVIDER IDENTIFIER (NPI) NOT REPORTED ON PAPER/INTERNET CLAIM
1214	REPORTED REFERRING NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER IS INVALID
1215	REFERRING NATIONAL PROVIDER IDENTIFIER (NPI) NOT REPORTED ON PAPER/INTERNET CLAIM
1216	REPORTED SERVICE FACILITY NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER IS INVALID
1217	SERVICE FACILITY NATIONAL PROVIDER IDENTIFIER (NPI) NOT REPORTED ON CLAIM
1218	ATTENDING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER IS INVALID
1219	ATTENDING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NOT REPORTED ON CLAIM
1220	OPERATING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER IS INVALID
1221	OPERATING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NOT REPORTED ON CLAIM
1222	OTHER OPERATING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER IS INVALID
1223	OTHER OPERATING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI) NOT REPORTED ON CLAIM

1224	CLAIM RENDERING NATIONAL PROVIDER IDENTIFIER (NPI) DOES NOT MATCH LEGACY NUMBER ON FILE
1225	ORDERING PROVIDER - NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER NOT ON FILE/ACTIVE
1226	MULTIPLE SERVICE LOCATION FOR ORDERING NATIONAL PROVIDER IDENTIFIER (NPI) - DEFAULT USED
1227	REFERRING PROVIDERS NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER NOT ON FILE
1228	ORDERING PROVIDER & BILLING PROVIDER CANNOT BE THE SAME
1229	ORDERING PROVIDER & RENDERING PROVIDER CANNOT BE THE SAME
1230	REFERRING PROVIDER'S NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER NOT ON FILE
1231	REFERRING AND BILLING PROVIDER CANNOT BE THE SAME
1232	REFERRING AND RENDERING PROVIDER CANNOT BE THE SAME
1233	ATTENDING PROVIDER'S NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER NOT ON FILE
1234	REFERRING AND BILLING PROVIDER CANNOT BE THE SAME
1235	EMERGENCY SERVICE - ORDERING PROVIDER NOT REVALIDATED
1236	EMERGENCY SERVICE - REFERRING PROV NOT REVALIDATED - HEADER
1237	EMERGENCY SERVICE - REFERRING PROV NOT REVALIDATED - DETAIL
1239	REFERRING PROVIDER REQUIRED - DETAIL
1240	DME REQUIRES REFERRING PHYSICIAN - DETAIL
1241	DME REQUIRES REFERRING OD OR PHYS - DETAIL
1242	HOME HEALTH REQUIRES REFERRING PHYSICIAN - DETAIL
1243	PUBLIC SCHOOL REQUIRES REFERRING PHYSICIAN - DETAIL
1244	ATTENDING PROVIDER MUST BE AN INDIVIDUAL - HEADER
1245	REFERRING PROVIDER MUST BE AN INDIVIDUAL - DETAIL
1246	ORDERING PROVIDER MAY NOT BE CHIP ONLY
1247	REFERRING PROVIDER MAY NOT BE CHIP ONLY
1248	REFERRING PROVIDER REQUIRED FOR WAV - DETAIL
1249	REFERRING PROV MUST BE AN INDIVIDUAL FOR WAV - DETAIL
1250	REFERRIING AND BILLING CANNOT BE THE SAME - HEADER
1260	Taxonomy for Billing ID Doesn’t Match (TAXONOMY SUBMITTED DOES NOT MATCH FOR BILLING NPI - National Provider Identifier)
1261	ZIP Code for Billing ID Doesn’t Match (FIVE DIGIT ZIP DOES NOT MATCH FOR BILLING NPI - National Provider Identifier)
1262	ZIP Code Extension for Billing ID Doesn’t Match (FOUR DIGIT ZIP EXTENSION DOES NOT MATCH FOR BILLING NPI - National Provider Identifier)
1263	Taxonomy for Rendering ID Doesn’t Match (TAXONOMY SUBMITTED DOES NOT MATCH FOR RENDERINGNPI - National Provider Identifier)
1264	ZIP Code for Rendering ID Doesn’t Match (FIVE DIGIT ZIP DOES NOT MATCH FOR RENDERING NPI - National Provider Identifier)
1265	ZIP Code Extension for Rendering ID Doesn’t Match (FOUR DIGIT ZIP EXTENSION DOES NOT MATCH FOR RENDERING NPI - National Provider Identifier)
1267	The National Provider Identifier (NPI) for Facility ID Doesn’t Match (FACILITY NPI REPORTED DOES NOT MATCH LEGACY, LEGACY USED)
1268	ZIP Code for Facility ID Doesn’t Match (5 DIGIT ZIP DOES NOT MATCH FOR FACILITY NPI - National Provider Identifier)
1269	ZIP Code Extension for Facility ID Doesn’t Match (FOUR DIGIT ZIP EXTENSION DOES NOT MATCH FOR FACILITY NPI - National Provider Identifier)

1270	Legacy Data used for Billing ID
1271	The National Provider Identifier (NPI) Data used for Billing ID
1272	Tax ID Data used for Billing ID
1273	DEFAULT LEGACY ID USED FOR BILLING ID
1274	Default Legacy ID used for Billing ID
1275	Default National Provider Identifier (NPI) Data used for Billing ID
1276	Only Tax ID Submitted
1277	Legacy Data used for Rendering ID
1278	The National Provider Identifier (NPI) Data used for Rendering ID
1279	Default Legacy ID used for Rendering ID
1280	Legacy Data used for Facility ID
1281	The National Provider Identifier (NPI) Data used for Facility ID
1282	Default Legacy ID used for Facility ID
1283	THE NATIONAL PROVIIDER IDENTIFIER (NPI) DATA USED FOR FACILITY ID
1284	DEFAULT LEGACY ID USED FOR FACILITY ID
1285	DEFAULT NATIONAL PROVIIDER IDENTIFIER (NPI) DATA USED FOR FACILITY ID
1500	RECORDS SHOW, LAB PROCEDURE WAS PAID 100% BY MEDICARE
2000	MEDICARE D ON FILE. NO A AND B THIRD PARTY LIABILITY (TPL) RECORD FOUND
2001	NO MEDICARE D ON FILE. A AND / OR B THIRD PARTY LIABILITY (TPL) RECORD FOUND
2002	RECIPIENT ELIGIBILITY EFFECTIVE DATE IS GREATER THAN THE DATE OF SERVICE ON THE CLAIM
2003	RECIPIENT IS NOT ELIGIBLE FOR CLAIM DATE(S) OF SERVICE BILLED
2006	RECIPIENT (ALIEN) IS ELIGIBLE FOR MEDICAL EMERGENCY SERVICE ONLY FOR THE CLAIM DETAIL DATES OF SERVICE BILLED
2007	RECIPIENT (ALIEN) IS ELIGIBLE FOR MEDICAL EMERGENCY SERVICE ONLY FOR THE CLAIM DATES OF SERVICE BILLED
2009	RECIPIENT HAS PCO (PRIVATE COVERAGE OPTION) COVERAGE ON CLAIM DATES
2010	PROVIDER NOT ELIGIBLE TO BILL FOR CONSOLIDATED COMMUNITY REPORTING (CCR)
2011	SERVICE IS CAPITATED UNDER LONG TERM CARE CAPITATED ASSISTANCE PROGRAM 2 (LTCCAP2 OR LCAP2)
2012	SERVICE IS EXCLUDED FROM LONG TERM CARE CAPITATED ASSISTANCE PROGRAM 2 (LTCCAP2 OR LCAP2)
2013	SERVICE IS CAPITATED UNDER AUTISM CAPITATION
2014	SERVICE IS EXCLUDED FROM AUTISM CAPITATION
2015	MATERNITY CARE CLAIMS - REVIEW ELIGIBILITY
2016	SERVICES ARE CAPITATED UNDER LONG TERM CARE CAPITATED ASSISTANCE PROGRAM 1 (LTCCAP1 OR LCAP1)
2017	RECIPIENT SERVICES COVERED BY HEALTH MAINTENANCE ORGANIZATION (HMO) PLAN
2018	RECIPIENT IS BEHAVIORAL HEALTH (BH) MANAGED CARE ORGANIZATION (MCO) ELIGIBLE ON DATE OF SERVICE
2019	RECIPIENTS ELIGIBLE IN THE SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLIMB OR SLMB) PROGRAM
2020	RECIPIENT'S CATEGORY AND PROGRAM STATUS CODE COMBINATION OF PS/17 IS NOT ELIGIBLE FOR INPATIENT HOSPITAL CARE SERVICES OR LONG TERM CARE SERVICES
2021	THE RECIPIENT'S CATEGORY IS NOT ELIGIBLE FOR NON-MEDICARE COVERED SERVICES THERE IS NO MEDICARE APPROVED AMOUNT ON YOUR CLAIM FOR LONG TERM CARE (LTC) CLAIMS - YOU ARE BILLING FOR DAYS OTHER THAN MEDICARE COINSURANCE DAYS

2022	RECIPIENT IS NOT ENROLLED WITH THE MANAGED CARE ORGANIZATION (MCO) ON THE ADMISSION DATE BILLED
2023	RECIPIENT IS IN HEALTH CARE BENEFIT PACKAGE (HCBP) 9 - COST SHARING ONLY
2025	THE RECIPIENT IS A STATE BLIND PENSION AND IS NOT ELIGIBLE FOR INPATIENT HOSPITAL CARE
2026	THE DEPARTMENT'S RECORDS INDICATE THAT THIS RECIPIENT WAS ELIGIBLE FOR ONLY PART OF THIS HOSPITALIZATION
2027	THERE APPEARS TO BE A DISCREPANCY BETWEEN THE DATE OF DEATH ON THE DEPARTMENT'S FILE AND THE DATE OF SERVICE ON YOUR CLAIM. DATE OF DEATH IS PRIOR TO THE DATE OF SERVICE.
2028	THIS RECIPIENT'S CATEGORY IS NOT ELIGIBLE FOR LONG TERM CARE SERVICES OR SERVICES PROVIDED IN A LONG TERM CARE FACILITY
2029	THE RECIPIENT IS NOT ELIGIBLE FOR THIS PROGRAM; YOU SHOULD BILL THE DEPARTMENT OF HEALTH
2030	WAIVER SERVICE INDICATED BUT RECIPIENT NOT ELIGIBLE
2031	BEHAVIORAL HEALTH CARVE OUT REQUIRES MANUAL REVIEW
2032	SERVICE MUST BE BILLED TO MEDICAL ASSISTANCE BEHAVIORAL HEALTH MANAGED CARE ORGANIZATION
2033	SERVICE MUST BE BILLED TO THE MEDICAL ASSISTANCE PHYSICAL HEALTH MANAGED CARE ORGANIZATION
2034	VETERAN'S RECIPIENT DOES NOT HAVE FACILITY CODE 32
2035	VETERAN'S NURSING FACILITY BILLING FOR NON-VETERANS RECIPIENT
2036	NON-VETERAN NURSING FACILITY BILLING FOR VETERANS RECIPIENT
2037	MULTIPLE (CHILDREN WITH SPECIAL NEEDS) PH95 PERCENT RULES EXIST - HEADER
2038	MULTIPLE (CHILDREN WITH SPECIAL NEEDS) PH95 PERCENT RULES EXIST - DETAIL
2039	PH95 COPAYMENT PROCESSING ERROR - HEADER
2040	PH95 COPAYMENT DATABASE ERROR - HEADER
2041	HOSPICE SIA PAYMENT LIMITED TO LAST SEVEN DAYS OF LIFE
2042	HOSPICE SIA PAYMENT LIMITED TO LAST SEVEN DAYS OF LIFE
2043	CLAIM HAS BEEN SUSPENDED FOR RECIPIENT REVIEW
2044	CLAIM INDICATES RECIPIENT HAS EXPIRED
2045	RECIPIENT AGE 65+, COVERAGE DEFAULT HEALTHY PLUS
2046	COVERAGE FOR RECIPIENT DEFAULTED TO HEALTHY PLUS
2047	RECIPIENT HAS CONTIGOUS TMA (TRADIONAL MEDICAL ASSISTANCE) AND PCO (PRIVATE COVERAGE OPTION) COVERAGE ON DATE OF SERVICE
2051	CLAIMS DATES OF SERVICE SPAN THE HPA (HEALTHY PENNSYLVANIA/HEALTHY PA) IMPLEMENTATION
2052	FFS (FEE FOR SERVICE) CLAIM ASSIGNED MANAGED CARE PHYSICAL HEALTH (MPHTH) SERVICE PROGRAM
2053	FFS (FEE FOR SERVICE) CLAIM ASSIGNED MANAGED CARE BEHAVIORAL HEALTH (MBHTH) SERVICE PROGRAM
2054	FFS (FEE FOR SERVICE) CLAIM ASSIGNED COMBINATION FOR INSTITUTIONAL CONSOLIDATED COMMUNITY REPORTING / PERFORMANCE OUTCOME MEASUREMENT SYSTEM (CCR/EPOMS) ENCOUNTER SERVICE PROGRAM
2055	FFS (FEE FOR SERVICE) CLAIM ASSIGNED A PCO (PRIVATE COVERAGE OPTION) SERVICE PROGRAM
2056	NONCOVERED QMB (QUALIFIED MEDICARE BENEFICIARY) SERVICES ASSIGNED A SERVICE PROGRAM
2057	ENCOUNTER CLAIM ASSIGNED PCO (PRIVATE COVERAGE OPTION) SERVICE PROGRAM
2058	PCO (PRIVATE COVERAGE OPTION) ENCOUNTER ASSIGNED NON-PCO (PRIVATE COVERAGE OPTION) SERVICE PROGRAM
2059	PCO (PRIVATE COVERAGE OPTION) ENCOUNTER ASSIGNED PCO (PRIVATE COVERAGE OPTION) SERVICE PROGRAM

2060	FFS (FEE FOR SERVICE) CLAIM SUBMITTED BY PCO (PRIVATE COVERAGE OPTION) SUBMITTER
2061	CHC (Community Health Choices) 20 COVERED WITH NO MCHTH FOR DATE OF SERVICE
2062	CHC (Community Health Choices) 20 COVERED WITH NO MCHTH FOR ADMITION DATE
2063	FFS (FEE FOR SERVICE) CLAIM SUBMITTED BY CHC (Community Health Choices) PLAN
2064	FFS (FEE FOR SERVICE) CLAIM ASSIGNED MCHTH SERVICE PROGRAM
2065	RECIPIENT CHC (Community Health Choices) COVERED ON DATE OF SERVICE
2066	RECIPIENT CHC (Community Health Choices) COVERED ON ADMITION DATE
2067	CHC (Community Health Choices) RECIPIENT WITH NO VALID POPULATION GROUP ID
2068	CHC (Community Health Choices) ENCOUNTER DATE OF SERVICE NOT WITHIN DATE RANGE
2069	RESERVED FOR CHC (Community Health Choices) PROJECT
2070	RESERVED FOR CHC (Community Health Choices) PROJECT
2071	RECIPIENT DATE OF BIRTH ON THE CLIENT INFORMATION SYSTEM (CIS) FILE IS NOT VALID
2078	GENERAL ASSISTANCE (GA) PROGRAM RECIPIENTS ARE LIMITED TO EMERGENCY TRANSPORTATION SERVICES ONLY
2079	A MANUAL REVIEW IS REQUIRED TO VERIFY THE AGE OF THIS RECIPIENT
2080	PREGNANCY INDICATION CAN ONLY BE INDICATED FOR FEMALE RECIPIENTS - RECIPIENT NOT FEMALE
2081	NEWBORN RECIPIENT IDENTIFICATION IS NOT ON FILE
2082	NEWBORN ELIGIBILITY MANAGED CARE ORGANIZATION (MCO) MATERNITY CARE PROCESS
2083	NEWBORN ELIGIBILITY MANAGED CARE ORGANIZATION (MCO) 30 DAY EXEMPTION REACHED
2084	NEWBORN NOT ELIGIBLE ON DATE OF BIRTH
2085	NEWBORN NOT COVERED BY MANAGED CARE ON DATE OF BIRTH
2086	THE MANAGED CARE ORGANIZATION CODE FOR THIS NEWBORN IS NOT CORRECT
2087	DATE OF BIRTH ON CLAIM DOES NOT MATCH DATE OF BIRTH ON FILE
2088	NEWBORN GENDER NOT PRESENT
2089	DATE OF BIRTH NOT WITHIN ADMISSION AND DISCHARGE DATES
2090	RECIPIENT DATE OF BIRTH (DOB) GREATER THAN THE CLAIM 'TO' DATE OF SERVICE
2091	MATERNITY CARE CLAIM SUBMITTED INCORRECTLY. THE WRONG MODIFIER WAS BILLED FOR YOUR COUNTY
2092	PHYSICAL HEALTH DIAGNOSIS WITH TELE-MEDICINE CONSULTATION
2093	MODIFIER/RECIPIENT ELIGIBILITY MISMATCH - MATERNITY CARE
2100	PUBLIC INTERMEDIATE/INDEPENDENT CARE FACILITIES / MENTALLY RETARDED / OTHER RELATED CONDITIONS (ICF/MR/ORC) RECIPIENT - NON-COMPOUND DRUG
2109	RECIPIENT HAS PCO (PRIVATE COVERAGE OPTION) COVERAGE FOR CLAIM DATES
2111	SERVICE IS CAPITATED UNDER LONG TERM CARE CAPITATED ASSISTANCE PROGRAM 2 (LTCCAP2 OR LCAP2)
2112	SERVICE IS EXCLUDED FROM LONG TERM CARE CAPITATED ASSISTANCE PROGRAM 2 (LTCCAP2 OR LCAP2)
2113	SERVICE IS CAPITATED UNDER AUTISM CAPITATION
2114	SERVICE IS EXCLUDED FROM AUTISM CAPITATION
2116	SERVICES ARE CAPITATED UNDER LONG TERM CARE CAPITATED ASSISTANCE PROGRAM 1 (LTCCAP1 OR LCAP1)
2117	RECIPIENT MEDICAL ASSISTANCE (MA) MANAGED CARE ORGANIZATION (MCO) ELIGIBLE ON ADMISSION DATE

2118	RECIPIENT BEHAVIORAL HEALTH (BH) MEDICAL ASSISTANCE (MA) MANAGED CARE ORGANIZATION (MCO) ELIGIBLE
2119	NOT USED
2120	PS/17 NOT ELIGIBLE FOR INPATIENT OR LONG TERM CARE (LTC) SERVICES
2121	HEALTH CARE BENEFIT PACKAGE (HCBP) INELIGIBLE FOR INPATIENT / LONG TERM CARE (LTC) SERVICES
2122	REVIEW MEDICAL ASSISTANCE ELIGIBILITY
2123	RECIPIENT NOT ELIGIBLE FOR ALL DAYS BILLED
2124	SPECIAL PHARMACEUTICAL BENEFIT PROGRAM (SPBP) COVERAGE IS NOT ACTIVE FOR ALL DATE OF SERVICE (DOS) ON CLAIM
2125	RECIPIENT HAS PHYSICAL HEALTH (PH) MEDICAL ASSISTANCE (MA) MANAGED CARE ORGANIZATION (MCO) COVERAGE ON ADMITION DATE
2126	CHC (Community Health Choices) CARVEOUT TABLE BYPASS FOR DATE OF SERVICE
2127	CHC (Community Health Choices) CARVEOUT TABLE BYPASS FOR ADMISSION DATE
2128	PH (PHYSICAL HEALTH) CARVEOUT TABLE BYPASS FOR DATE OF SERVICE
2129	PH (PHYSICAL HEALTH) CARVEOUT TABLE BYPASS FOR ADMITION DATE
2130	RESERVED FOR CHC (Community Health Choices) PROJECT
2131	RESERVED FOR CHC (Community Health Choices) PROJECT
2132	RESERVED FOR CHC (Community Health Choices) PROJECT
2133	RESERVED FOR CHC (Community Health Choices) PROJECT
2134	RESERVED FOR CHC (Community Health Choices) PROJECT
2135	RESERVED FOR CHC (Community Health Choices) PROJECT
2200	MEDICARE PART D CO-PAY IS NOT REIMBURSABLE
2201	CLAIM BILLED FOR MEDICARE CO-PAY BILLED INCORRECTLY
2202	EMERGENCY CLAIM BYPASS FOR DUAL ELIGIBLE
2500	YOUR CLAIM WAS DENIED DUE TO MEDICARE PART A RESOURCE AVAILABLE FOR THIS RECIPIENT. NO ATTACHMENT WAS PROVIDED FOR THIS CLAIM. NO MEDICARE DENIAL OR EXHAUSTION INDICATED.
2501	YOUR CLAIM WAS SUSPENDED FOR MANUAL REVIEW DUE TO MEDICARE A DENIAL / EXHAUSTION. YOUR CLAIM MAY BE DENIED IF ATTACHMENT IS FOUND TO BE INSUFFICIENT
2502	YOUR CLAIM WAS DENIED DUE TO MEDICARE PART B RESOURCE AVAILABLE FOR THIS RECIPIENT. NO ATTACHMENT WAS PROVIDED FOR THIS CLAIM
2503	YOUR CLAIM WAS SUSPENDED FOR REVIEW DUE TO RECEIPT OF MEDICARE PART B ATTACHMENT. YOUR CLAIM MAY BE DENIED IF ATTACHMENT IS FOUND TO BE INSUFFICIENT
2504	YOUR CLAIM WAS DENIED DUE TO AN INSURANCE RESOURCE AVAILABLE FOR THIS RECIPIENT, NO ATTACHMENT WAS PROVIDED FOR THIS CLAIM
2505	YOUR CLAIM WAS SUSPENDED FOR MANUAL REVIEW DUE TO A DENIAL FROM THE THIRD PARTY RESOURCE. YOUR CLAIM MAY BE DENIED IF THE ATTACHMENT IS FOUND TO BE INSUFFICIENT
2506	INSURANCE DENIAL REQUIRED
2507	THIS PATIENT HAS TWO COVERAGE TYPES
2508	CLAIM DENIED FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) COVERAGE FOR NON LONG TERM CARE SERVICES.
2509	CLAIM DENIED FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) COVERAGE RELATED TO LONG TERM CARE SERVICES.
2510	THIS CLAIM WAS SUSPENDED FOR REVIEW DUE TO A THIRD PARTY RESOURCE FOR THIS RECIPIENT, YOUR CLAIM MAY BE DENIED IF THE ATTACHMENT IS FOUND TO BE INSUFFICIENT

2511	YOUR CLAIM WAS DENIED DUE TO AN INSURANCE RESOURCE AVAILABLE FOR THIS RECIPIENT, NO ATTACHMENT WAS PROVIDED FOR THIS CLAIM
2512	HEALTH MAINTENANCE ORGANIZATION (HMO) CO-PAY/NO THIRD PARTY LIABILITY (TPL) OR MEDICARE COVERAGE
2513	REGION CODE INVALID FOR PROGRAM
2514	CLAIM SUBMITTED DURING A TRANSFER PENALTY PERIOD
2515	TRANSFER PENALTY DENIAL - WAIVER
2516	YOUR CLAIM WAS SUSPENDED FOR MANUAL REVIEW TO VERIFY THE PROVIDER NUMBER ON THE DEPARTMENT'S RECORD FOR THIS RECIPIENT'S PATIENT PAY AMOUNT
2517	YOUR CLAIM WAS SUSPENDED FOR A MANUAL REVIEW TO VERIFY THE PATIENT PAY AMOUNT ENTERED ON YOUR CLAIM
2518	YOUR CLAIM WAS DENIED SINCE YOU HAVE NOT UTILIZED THIS RECIPIENT'S PATIENT PAY RESOURCE
2519	YOUR CLAIM WAS SUSPENDED FOR MANUAL REVIEW TO VERIFY THE PROVIDER NUMBER ON THE DEPARTMENT'S RECORD FOR THIS RECIPIENT'S PATIENT PAY AMOUNT
2520	LONG TERM CARE (LTC) PATIENT PAY RESOURCE NOT UTILIZED
2521	REVIEW GROSS PATIENT PAY AMOUNT - LONG TEARM CARE (LTC) Z TYPE.
2522	GROSS PATIENT PAY DOES NOT EQUAL THIRD PARTY LIABILITY (TPL) RECORDS
2523	PRIVATE DEDUCTIBLE AND/OR COINSURANCE IS PRESENT AND THE OTHER INSURANCE PAID = 0 AND PRIVATE DEDUCTIBLE AND PRIVATE COINSURANCE DOEST NOT EQUAL TOTAL CHARGES
2524	NOT A MEDICAL ASSISTANCE (MA) COVERED DRUG FOR DUAL ELIGIBLE
2525	EMERGENCY CLAIM NOT ALLOWED FOR DUAL ELIGIBLE
2526	THIRD PARTY LIABILITY (TPL) AMOUNT IS GREATER THAN ZERO ON CLAIM FOR DUAL ELIGIBLE
2527	DRUG REQUIRES PRIOR AUTHORIZATION FOR DUAL ELIGIBLE
2528	OVER THE COUNTER (OTC) EMERGENCY SUPPLY CLAIM FOR DUAL ELIGIBLE
2529	BILLED AMOUNT IS LESS THAN PATIENT PAY ON CLAIM
2530	HEALTH INSURANCE PREMIUM PAYMENT (HIPP) COVERAGE HAS BEEN EXHAUSTED.
2531	SUSPENDED TO VERIFY LIMITS OF RECIPIENT'S THIRD PARTY
2532	THIS CLAIM WAS DENIED DUE TO THE DRUG COVERAGE RESOURCE AVAILABLE FOR THIS RECIPIENT
2533	CLAIMIS CROSSOVER BUT NO MEDICARE COVERAGE ON FILE - HEADER
2534	THIRD PARTY LIABILITY (TPL) INDICATED BUT NO TPL ON FILE - DETAIL
2535	SUSPEND TO REVIEW THIRD PARTY LIABILITY (TPL) DENIAL - HEADER
2536	SUSPEND TO REVIEW THIRD PARTY LIABILITY (TPL) DENIAL - HEADER
2537	SUSPEND TO REVIEW THIRD PARTY LIABILITY (TPL) DENIAL - HEADER
2538	SUSPENDED FOR MANUAL REVIEW OF MEDICARE DENIAL
2539	MANUAL REVIEW OF MEDICARE COVERAGE EXHAUSTION
2540	SUSPEND TO REVIEW MEDICARE COVERAGE
2541	INFORMATION TO REVIEW MEDICARE COVERAGE
2542	YOU HAVE INDICATED THAT A MEDICARE EXPLANATION OF MEDICAL BENEFITS (EOMB) IS ON FILE. YOUR CLAIM HAS SUSPENDED FOR MANUAL REVIEW.
2543	COBA PREVENTATIVE PEDIATRIC CLAIM - DETAIL
2544	COBRA PRENATAL CLAIM - DETAIL

2545	COBRA COURT ORDERED RESOURCE CLAIM - DETAIL
2546	COBRA COURT ORDERED RESOURCE CLAIM - HEADER
2547	VERIFY LIMITS OF RECIPIENT'S THIRD PARTY COVERAGE
2548	VERIFY THE BEGIN DATE OF COVERAGE FOR THIRD PARTY
2549	VERIFY THE END DATE OF COVERAGE FOR THIRD PARTY RESOURCE
2550	YOUR CLAIM WAS DENIED DUE TO MEDICARE PART A RESOURCE AVAILABLE FOR THIS RECIPIENT. NO ATTACHMENT WAS PROVIDED FOR THIS CLAIM
2551	YOUR CLAIM WAS SUSPENDED FOR MANUAL REVIEW DUE TO MEDICARE A DENIAL / EXHAUSTION. YOUR CLAIM MAY BE DENIED IF ATTACHMENT IS FOUND TO BE INSUFFICIENT
2552	RECIPIENT HAS MEDICARE A/B. YOUR CLAIM WAS DENIED DUE TO MEDICARE PART B RESOURCE AVAILABLE FOR THIS RECIPIENT. NO ATTACHMENT WAS PROVIDED FOR THIS CLAIM.
2553	RECIPIENT HAS MEDICARE A/B. YOUR CLAIM WAS SUSPENDED FOR REVIEW DUE TO RECEIPT OF MEDICARE PART B ATTACHMENT. YOUR CLAIM MAY BE DENIED IF ATTACHMENT IS FOUND TO BE INSUFFICIENT
2554	YOUR CLAIM WAS DENIED DUE TO A INSURANCE RESOURCE AVAILABLE FOR THIS RECIPIENT, NO ATTACHMENT WAS PROVIDED FOR THIS CLAIM
2555	YOUR CLAIM WAS SUSPENDED FOR MANUAL REVIEW DUE TO A DENIAL FROM THE THIRD PARTY RESOURCE. YOUR CLAIM MAY BE DENIED IF ATTACHMENT IS FOUND TO BE INSUFFICIENT
2556	MEDICARE PART B DRUG - THIRD PARTY LIABILITY (TPL) AMOUNT EQUAL ZERO
2557	MEDICARE PART B DRUG - THIRD PARTY LIABILITY (TPL) AMOUNT GREATER THAN ZERO
2558	PATIENT PAY ON ADJUSTMENT DOES NOT MATCH ORIGINAL CLAIM
2559	THIRD PARTY LIABILITY (TPL) 835 BALANCING EDIT
2560	CLAIM LINE VOIDED FOR THIRD PARTY LIABILITY (TPL) RECOVERY
2561	ORIGINAL DETAIL DENIED / NOT INCLUDED IN THIRD PARTY LIABILITY (TPL) RECOVERY
2562	RECIPIENT HAS MEDICARE B, NO MEDICARE B DENIAL OR PAYMENT INDICATED
2563	RECIPIENT HAS PRIVATE INSURANCE, NO INSURANCE PAYMENT OR DENIAL INDICATED
2564	ACT 62 CLAIM
2565	ACT 62 COVERAGE - NO DENIAL / PAYMENT / EXHAUSTION ON CLAIM
2566	ACT 62 - DENIAL REVIEW
2567	ACT 62 - EXHAUSTION REVIEW
2568	ACT 62 - BENEFITS EXHAUSTED
2569	ACT 62 EXHAUSTION IN HISTORY
2570	COORDINATION OF BUSINESS (COB) BYPASS FOR PRESCRIPTION (RX) COVERAGE
2571	PHARMACY THIRD PARTY LIABILITY (TPL) ERROR STATUS CODE (ESC) FOR FUTURE USE
2572	CLAIM DENIED FOR MISSING PCO (PRIVATE COVERAGE OPTION) THIRD PARTY LIABILITY (TPL) RESOURCE R
2573	CLAIM DENIED FOR MISSING PCO (PRIVATE COVERAGE OPTION) BYPASS CRITERIA
2574	CLAIM DENIED FOR NO COORDINATION OF BUSINESS (COB) BYPASS, THIRD PARTY LIABILITY (TPL) AMOUNT GREATER THAN ZERO.
2575	COB BYPASS FOR PCO (PRIVATE COVERAGE OPTION) THIRD PARTY LIABILITY (TPL) RESOURCE R
2576	NO PCO (PRIVATE COVERAGE OPTION) PAYMENT/DENIAL/EXHAUSION INDICATED - DETAIL
2577	NO PCO (PRIVATE COVERAGE OPTION) PAYMENT/DENIAL/EXHAUSION INDICATED - HEADER

2578	PCO (PRIVATE COVERAGE OPTION) DENIAL INDICATED
2579	PCO (PRIVATE COVERAGE OPTION) DENIAL INDICATED
2580	PCO (PRIVATE COVERAGE OPTION) EXHAUSTION INDICATED
2581	PCO (PRIVATE COVERAGE OPTION) EXHAUSTION INDICATED
2582	REVIEW CLAIM LINE PCO (PRIVATE COVERAGE OPTION) PAYMENT INFORMATION
2583	REVIEW CLAIM LEVEL PCO (PRIVATE COVERAGE OPTION) PAYMENT INFORMATION
2584	THIRD PARTY LIABILITY (TPL) BYPASS PSF/15 WITH PSF/00/10/14
2585	RECIPIENT NOT ELIGIBLE FOR NURSING FACILITY (NF) SERVICES
2999	SUSPENDED CLAIM REQUIRES MANUAL REVIEW BY THE DEPARTMENT TO DETERMINE RECIPIENT ELIGIBILITY
3000	PRIOR AUTHORIZATION (PA) NUMBER INVALID FORMAT
3002	NATIONAL DRUG CODE (NDC) / PROCEDURE CODE REQUIRES PRIOR AUTHORIZATION WHICH IS NOT FOUND, MISSING, OR INVALID
3003	CLAIM REQUIRES AUTOMATED UTILIZATION REVIEW (AUR) - NOT FOUND, MISSING OR INVALID
3004	EXISTING PRIOR AUTHORIZATION (PA) NOT VALID FOR DUAL ELIGIBLE
3005	QUANTITY INVALID FOR PRIOR AUTHORIZATION
3006	PRIOR AUTHORIZATION (PA) FOUND DOES NOT MATCH CLAIM CRITERIA
3007	INVALID MANAGED CARE ORGANIZATION (MCO) PHARMACY PRIOR AUTHORIZATION SUBMITTED
3020	PROCEDURE CODE - TOOTH NUMBER / LETTER OR MODIFIER COMBINATION DOES NOT MATCH THE APPROVED VALUES ON THE PRIOR AUTHORIZATION
3021	PROCEDURE CODE / MODIFIER COMBINATION DOES NOT MATCH THE APPROVED COMBINATION FOR THIS PRIOR AUTHORIZATION NUMBER
3022	CLAIM DETAIL PROCEDURE CODE - TOOTH NUMBER / LETTER OR MODIFIER COMBINATION DOES NOT MATCH THE APPROVED PRIOR AUTHORIZATION - DETAIL
3023	NATIONAL DRUG CODE (NDC) NUMBER DOES NOT MATCH THE APPROVED COMBINATION FOR THIS PRIOR AUTHORIZATION
3024	THE INVOICE CLAIM LINE QUANTITY EXCEEDS THE PRIOR AUTHORIZATION REQUEST QUANTITY
3025	CLAIM DETAIL DATE OF SERVICE IS AFTER THE PRIOR AUTHORIZATION EXPIRATION DATE - DETAIL
3026	THIS PROCEDURE CODE / MODIFIER - NATIONAL DRUG CODE (NDC) OR PROGRAM EXCEPTION / LONG TERM CARE (LTC) ON THE CLAIM DETAIL WAS DENIED ON YOUR PRIOR AUTHORIZATION REQUEST
3027	THE PROVIDER MEDICAL ASSISTANCE (MA) IDENTIFICATION NUMBER ON THE INVOICE DOES NOT MATCH THE PROVIDER MEDICAL ASSISTANCE (MA) IDENTIFICATION NUMBER ON THE APPROVED PRIOR AUTHORIZATION REQUEST
3028	THE PRESCRIBER LICENSE NUMBER DOES NOT MATCH THE PRESCRIBER LICENSE NUMBER ON THE PRIOR AUTHORIZATION REQUEST
3029	NECESSARY INFORMATION NOT AVAILABLE TO MAKE A FINAL DECISION FOR ADMISSION CERTIFICATION REQUEST - DETAIL
3030	CLAIM DETAIL DATE OF SERVICE OR ADMISSION DATE NOT EQUAL TO ADMISSION DATE OR WITHIN THE APPROVED TIME FRAME ON ADMISSION CERTIFICATION - DETAIL
3031	CLAIM DATE OF SERVICE OR ADMISSION DATE NOT EQUAL TO ADMISSION DATE OR WITHIN THE APPROVED TIME FRAME ON ADMISSION CERTIFICATION - HEADER
3032	CLAIM PROCEDURE CODE DOES NOT MATCH THE ADMISSION CERTIFICATION ON FILE
3033	CLAIM DETAIL PROCEDURE CODE DOES NOT MATCH THE ADMISSION CERTIFICATION ON FILE
3034	OUR RECORDS INDICATE THE DEPARTMENT HAS ALREADY PAID FOR THIS PROGRAM EXCEPTION OR PENNSYLVANIA DEPARTMENT OF AGING (PDA) WAIVER SERVICE - HEADER

3035	OUR RECORDS INDICATE THAT ALL SERVICES USING THE INDICATED PRIOR AUTHORIZATION HAVE ALREADY BEEN PAID BY THE DEPARTMENT OF HUMAN SERVICES - DETAIL
3036	THE ADMISSION CERTIFICATION NUMBER HAS BEEN DENIED - DETAIL
3037	THE RECIPIENT'S IDENTIFICATION NUMBER DOES NOT MATCH THE RECIPIENT'S ID NUMBER ON THE PRIOR AUTHORIZATION RECORD
3038	THE PROVIDER MEDICAL ASSISTANCE (MA) IDENTIFICATION NUMBER DOES NOT MATCH THE PROVIDER MEDICAL ASSISTANCE (MA) IDENTIFICATION NUMBER ON THE DEPARTMENT'S ADMISSION CERTIFICATION FILE
3039	THE ADMISSION CERTIFICATION NUMBER HAS BEEN DENIED - HEADER
3040	THE RECIPIENT'S IDENTIFICATION NUMBER DOES NOT MATCH THE RECIPIENT'S IDENTIFICATION NUMBER ON THE DEPARTMENT'S ADMISSION CERTIFICATION FILE - HEADER
3041	DATE OF SERVICE IS BEFORE OR AFTER THE PRIOR AUTHORIZATION (PA) DATE - HEADER
3042	AUTOMATED UTILIZATION REVIEW (AUR) REQUIRED. THE ADMISSION CERTIFICATION NUMBER PLACE OF SERVICE REVIEW / DIAGNOSIS RELATED GROUP / CONCURRENT HOSPITAL REVIEW (PSR/DRG/CHR) IS MISSING, NOT NUMERIC, OR NOT ACCEPTABLE ON THE DEPARTMENT'S RECORDS. (HEADER)
3043	BILLING PROVIDER IDENTIFICATION DOES NOT MATCH BILLING PROVIDER
3044	OUTLIER DAYS REQUESTED, BUT NOT PRIOR AUTHORIZED
3045	DIAGNOSIS RELATED GROUP (DRG) OUTLIER REDUCED
3046	INVALID PROCEDURE CODE FOR AUTOMATED UTILIZATION REVIEW (AUR) REASON CODE 003
3047	CASE DID NOT MEET LATE PICKUP REQUIREMENTS
3048	NON-EMERGENCY DURABLE MEDICAL EQUIPMENT (DME) OR MEDICAL SUPPLIES PURCHASE REQUIRE PRIOR AUTHORIZATION IF MORE THAN $100
3049	THIS PROCEDURE CODE WAS DENIED ON YOUR PRIOR AUTHORIZATION REQUEST
3050	NECESSARY INFORMATION IS NOT AVAILABLE TO MAKE A FINAL DECISION FOR ADMISSION CERTIFICATION REQUEST
3052	NOT USED
3053	RECORDS INDICATE PRIOR AUTHORIZATION (PA) DENIED OR NOT FINALIZED
3054	THE ADMISSION WAS DENIED DUE TO READMISSION POLICY
3055	BILLED AMOUNT MUST BE EQUAL TO OR LESS THAN AUTHORIZED AMOUNT
3056	INTERNAL FORMULA BYPASS FOR EDIT 3002 - AT30
3057	CLIENT INFORMATION SYSTEM (CIS) ASSIGNED HEALTH CARE BENEFIT PACKAGE (HCBP) FOR PROGRAM EXCEPTION
3058	UNITS BILLED ARE MORE THAN REMAINING UNITS
3059	PROVIDER INDICATED EMERGENCY MEDICAL CONDITION
3060	PROFESSIONAL COMPONENT BILLED IN PLACE OF SERVICE (POS) 22 OR 23
3061	PROVIDER PREVENTABLE CONDITION REPORTED
3062	HEALTHCARE ACQUIRED CONDITION REPORTED
3500	PROCEDURE RE-BUNDLES TO A MORE COMPREHENSIVE PROCEDURE
3501	PROCEDURE RE-BUNDLES TO A MORE COMPREHENSIVE PROCEDURE ON A PREVIOUSLY PAID CLAIM
3505	PROCEDURE RE-BUNDLES TO A MORE COMPREHENSIVE PROCEDURE ON THIS CLAIM
3506	PROCEDURE RE-BUNDLES TO A MORE COMPREHENSIVE PROCEDURE ON A PREVIOUSLY PAID CLAIM
3510	BILATERAL OR UNILATERAL PROCEDURE IS A DUPLICATE TO A PROCEDURE ON THIS CLAIM
3511	BILATERAL OR UNILATERAL PROCEDURE IS A DUPLICATE TO A PROCEDURE ON A PREVIOUSLY PAID CLAIM

3512	PROCEDURE CODE EXCEEDS THE MAXIMUM ALLOWED OCCURRENCES OF THE PROCEDURE OR INCORRECT MODIFIER USAGE.
3513	PROCEDURE CODE EXCEEDS THE MAXIMUM ALLOWED OCCURRENCES OF A PROCEDURE ON A PREVIOUSLY PAID CLAIM
3514	PROCEDURE IS A DUPLICATE TO ANOTHER PROCEDURE ON THIS CLAIM
3515	PROCEDURE IS A DUPLICATE TO ANOTHER PROCEDURE ON A PREVIOUSLY PAID CLAIM
3516	PROCEDURE ON A PREVIOUSLY PAID CLAIM IS A DUPLICATE TO A CURRENT PROCEDURE
3517	PROCEDURE ON A PREVIOUSLY PAID CLAIM EXCEEDS THE MAXIMUM ALLOWED
3520	PROCEDURE IS INCIDENTAL TO ANOTHER PROCEDURE OR SERVICE ON THIS CLAIM
3521	PROCEDURE IS INCIDENTAL TO A PREVIOUSLY PAID CLAIM
3525	NCCI PROCEDURE IS INCIDENTAL TO ANOTHER PROCEDURE OR SERVICE ON THIS CLAIM
3526	NCCI PROCEDURE IS INCIDENTAL TO ANOTHER PROCEDURE OR SERVICE ON A PREVIOUSLY PAID CLAIM
3528	MEDICALLY UNLIKELY EDITS (MUE) UNITS EXCEEDS CMS (CENTERS FOR MEDICARE & MEDICAID SERVICES) DAILY LIMIT PER DETAIL
3530	PROCEDURES ARE MUTUALLY EXCLUSIXE TO ANOTHER PROCEDURE ON THIS CLAIM
3531	PROCEDURE IS MUTUALLY EXCLUSIVE TO A PREVIOUSLY PAID CLAIM
3535	NCCI PROCEDURE IS INCIDENTAL TO OTHER PROCEDURE OR SERVICE ON THIS CLAIM
3536	NCCI PROCEDURE IS INCIDENTAL TO PREVIOUSLY PAID CLAIM
3540	SURGICAL SERVICE DOES NOT ALLOW FOR AN ASSISTANT SURGEON
3541	SURGICAL SERVICE REQUIRES PROGRAM EXCEPTION FOR AN ASSISTANT SURGEON
3550	THE AGE FOR THE RECIPIENT IS OUTSIDE OF THE AGE RESTRICTION FOR THIS PROCEDURE CODE
3551	THE GENDER OF THE RECIPIENT DOES NOT REFLECT THE GENDER FOR THIS PROCEDURE CODE
3552	PROCEDURE / SERVICE HAS BEEN IDENTIFIED AS COSMETIC
3553	PROCEDURE IS NOT VALID FOR THE DATE OF SERVICE
3554	PROCEDURE / SERVICE HAS BEEN IDENTIFIED AS EXPERIMENTAL
3555	THE MEANS FOR PROVIDING THIS PROCEDURE / SERVICE HAS BEEN IDENTIFIED AS OUTDATED
3560	PREOPERATIVE PROCEDURE CODE OCCURRED WITHIN ONE DAY OF SURGICAL PROCEDURE
3561	PROCEDURE OCCURRED WITHIN ONE DAY OF PREVIOUSLY PAID INPATIENT SURGICAL PROCEDURE
3562	VISIT OCCURRED WITHIN THE ASSOCIATED SURGICAL POSTOPERATIVE PERIOD ON THIS CLAIM
3563	VISIT OCCURRED WITHIN THE ASSOCIATED SURGICAL POSTOPERATIVE PERIOD ON A PREVIOUSLY PAID CLAIM
3564	VISIT NOT REIMBURSABLE WITH CURRENT BILLED PROCEDURE / SERVICE
3565	VISIT NOT REIMBURSABLE WITH PREVIOUSLY BILLED PROCEDURE / SERVICE
3600	INTERNAL ERROR
3601	INTERNAL ERROR
3602	DIAGNOSIS POINTER REQUIRED
3603	UNITS / DATE RANGE RESTRICTION
3604	UNITS NOT EQUAL TO SITE SPECIFIC MODIFIER
3605	RELATED PROCEDURES CANNOT BE BILLED ON SAME DATE OF SERVICE (DOS)
3606	DIAGNOSIS POINTER REQUIRED ON CLAIM
3611	DIABETIC SUPPLY FREQUENCY APPLY

3612	DIABETIC SUPPLY FREQUENCY REVIEW
3613	DURABLE MEDICAL EQUIPMENT (DME) MAX PAYMENT APPLY
3614	DURABLE MEDICAL EQUIPMENT (DME) MAX PAYMENT REVIEW
3615	DURABLE MEDICAL EQUIPMENT (DME) OWN HISTORY APPLY
3616	DURABLE MEDICAL EQUIPMENT (DME) OWN HISTORY REVIEW
3617	DURABLE MEDICAL EQUIPMENT (DME) RENT HISTORY APPLY
3618	DURABLE MEDICAL EQUIPMENT (DME) RENT HISTORY REVIEW
3619	DURABLE MEDICAL EQUIPMENT (DME) RENTAL VS OWN HISTORY APPLY
3620	DURABLE MEDICAL EQUIPMENT (DME) RENTAL VS OWN HISTORY REVIEW
3621	DURABLE MEDICAL EQUIPMENT (DME) REPLACE APPLY
3622	DURABLE MEDICAL EQUIPMENT (DME) REPLACE REVIEW
3623	LAB PANEL APPLY
3624	LAB PANEL REVIEW
3625	DIAGNOSIS REVIEW-MANIPULATION UNDER ANESTHESIA APPLY
3626	DIAGNOSIS REVIEW-MANIPULATION UNDER ANESTHESIA REVIEW
3627	MANIPULATION UNDER ANESTHESIA FREQUENCY APPLY
3628	MANIPULATION UNDER ANESTHISIA FREQUENCY REVIEW
3629	PREOPERATIVE OR POSTOPERATIVE DIAGNOSIS APPLY
3630	PREOPERATIVE OR POSTOPERATIVE DIAGNOSIS REVIEW
3631	LINE QUANTITY EXCESS LIMIT APPLY
3632	LINE QUANTITY EXCESS LIMIT REVIEW
3633	RELATED MANIPULATION UNDER ANESTHESIA APPLY
3634	RELATED MANIPULATION UNDER ANESTHESIA REVIEW
3635	PROVIDER SPECIALTY/PROCEDURE CODE MISMATCH APPLY
3636	PROVIDER SPECIALTY/PROCEDURE CODE MISMATCH REVIEW
3637	SURGICAL PROCEDURE DATE OF SERVICE (DOS) APPLY
3638	SURGICAL PROCEDURE DATE OF SERVICE (DOS) REVIEW
3639	SLEEP STUDY PLACE OF SERVICE (POS) INVALID APPLY
3640	SLEEP STUDY PLACE OF SERVICE (POS) INVALID REVIEW
3641	INJECTION QUANTITY APPLY
3642	INJECTION QUANTITY REVIEW
3643	CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) BI-LEVEL POSITIVE AIRWAY PRESSURE (BIPAP) SUPPLY FREQUENCY APPLY
3644	CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) BI-LEVEL POSITIVE AIRWAY PRESSURE (BIPAP) SUPPLY FREQUENCY REVIEW
3645	MAINTENANCE & SERVICES COVERED UNDER PRODUCT WARRANTY APPLY
3646	MAINTENANCE & SERVICES COVERED UNDER PRODUCT WARRANTY REVIEW
3647	PRODUCT COVERED UNDER WARRANTY APPLY
3648	PRODUCT COVERED UNDER WARRANTY REVIEW

3649	MAINTENANCE OF PRODUCT COVERED UNDER WARRANTY APPLY
3650	MAINTENANCE OF PRODUCT COVERED UNDER WARRANTY REVIEW
3651	REVENUE CODE INCOMPATIBLE WITH HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCPS) CODE APPLY
3652	REVENUE CODE INCOMPATIBLE WITH HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCPS) CODE REVIEW
3653	CLAIM UNDER REVIEW
3654	INVESTICLAIM INITIATED ADJUSTMENT
3655	INVESTICLAIM - MISREPRESENTED SERVICE
3656	INVESTICLAIM - DUPLICATE SERVICE
3657	INVESTICLAIM - NON-COVERED SERVICE
3658	INVESTICLAIM - ORIGINAL DETAIL PAID
3659	INVESTICLAIM - ORIGIGINAL DETAIL DENIED
3680	INTERNAL ARRAY SIZE EXCEEDED
3681	DATABASE SELECT FAILED
3682	WEB SERVICES ERROR
3683	INVESTICLAIM CONFIGURATION ERROR
3684	INVESTICLAIM SOCKET ERROR
3685	INVESTICLAIM RESPONSE ERROR
3686	INVESTICLAIM PACKAGE/REQUEST ERROR
3687	INVESTICLAIM DETAIL LEVEL PROCESS ERROR
3688	INVESTICLAIM CLAIM LEVEL PROCESS ERROR
3689	INVESTICLAIM FATAL PROCESS ERROR
3690	INTERNAL ERROR
3691	INTERNAL ERROR
3692	WEB SERVICE ERROR
3693	DATE OF SERVICE CANNOT BE BEFORE DATE OF BIRTH
3694	INTERNAL ERROR
3695	INTERNAL ERROR
3696	INTERNAL ERROR
3697	INVALID ACCOUNT
3698	INTERNAL ERROR
3699	CLAIM LINES GREATER THAN 100
3999	EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SCREENING FEE IS GREATER THAN THE ACA (AFFORDABLE CARE ACT) PCS RATE
4000	MANUALLY REVIEW ACA (AFFORDABLE CARE ACT) PCS EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) ELIGIBILITY
4001	EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) COMPLETE SCREEN
4002	NATIONAL DRUG CODE (NDC) INDICATES A NON-COVERED DRUG ON DATE OF SERVICE
4003	DRUG INDICATED HAS BEEN IDENTIFIED AS LESS THAN EFFECTIVE

4004	NATIONAL DRUG CODE (NDC) BILLED IS NOT ON FILE
4005	THIS IS AN FEDERALLY QUALIFIED HEALTH CENTER (FQHC) OR RURAL HEALTH CLINIC (RHC) CLAIM
4006	THIS IS NOT A VALID SUBMISSION OF AN FEDERALLY QUALIFIED HEALTH CENTER (FQHC) OR RURAL HEALTH CLINIC (RHC) CLAIM
4007	ALL INGREDIENTS ARE NON-COVERED ON DATE OF SERVICE (DOS)
4010	MODIFIER REQUIRES MEDICAL REVIEW
4011	THE MODIFIER IS EITHER NOT VALID OR NOT VALID IN COMBINATION WITH THE OTHER MODIFIERS BILLED ON THE CLAIM DETAIL
4012	MODIFIER 'SG' MAY ONLY BE BILLED BY AMBULATORY SURGICAL CENTER (ASC) / SPECIAL PROCEDURE UNIT (SPU) PROVIDER
4013	PROCEDURE CODE / NATIONAL DRUG CODE (NDC) IS NOT COVERED FOR DATE OF SERVICE
4014	NO PRICING SEGMENT ON FILE
4015	RENDERING PROVIDER WITH PROVIDER TYPE / SPECIALTY 08/083 MUST HAVE 'FP' MODIFIER
4017	ABORTION DIAGNOSIS / PROCEDURE INDICATED - HEADER
4018	ABORTION DIAGNOSIS / PROCEDURE INDICATED - DETAIL
4019	PROCEDURE CODE REQUIRES ATTACHMENT
4020	UNITS BILLED EXCEED ALLOWABLE UNITS FOR PROCEDURE. THE DEPARTMENT USED THE MAXIMUM QUANTITY ALLOWED FOR THE PROCEDURE / NATIONAL DRUG CODE (NDC) FOR THE TIME PERIOD BEING BILLED.
4021	RECIPIENT NOT ELIGIBLE FOR SERVICE PROVIDED, Confirm beneficiary number on claim = 10 digits
4022	ABORTION DIAGNOSIS / PROCEDURE INDICATED - HEADER
4023	THE NATIONAL DRUG CODE (NDC) BILLED IS INCONSISTENT WITH THE RECIPIENT'S GENDER
4024	MAXIMUM NUMBER OF REFILLS HAS BEEN REACHED
4025	THE NATIONAL DRUG CODE (NDC) BILLED IS INCONSISTENT WITH THE RECIPIENT'S AGE
4026	THE NATIONAL DRUG CODE (NDC) BILLED AND DAYS SUPPLY / QUANTITY DISPENSED ARE INCONSISTENT
4027	OBSERVATION REQUIRED REVENUE CODE 760 OR 762
4028	SERVICES CAN NOT BE BILLED ON AN 837I OR UB-92
4029	PRIMARY DIAGNOSIS BILLED IS NOT CONSISTENT WITH THE RECIPIENT'S AGE ON THIS CLAIM - DETAIL
4030	PRIMARY DIAGNOSIS IS NOT CONSISTENT WITH THE RECIPIENT'S AGE FOR THIS CLAIM - HEADER
4031	THE CLAIM DIAGNOSIS CODE IS INCONSISTENT WITH THE RECIPIENT'S GENDER
4032	THE PROCEDURE CODE BILLED IS NOT ON FILE
4033	INVALID PROCEDURE CODE MODIFIER COMBINATION
4034	THE PROCEDURE CODE BILLED IS INCONSISTENT WITH THE RECIPIENT'S AGE ON THE DATE OF SERVICE
4035	THE PROCEDURE CODE BILLED IS INCONSISTENT FOR THE RECIPIENT'S GENDER
4036	THE PROCEDURE CODE/MODIFIER BILLED IS NOT ALLOWED TO BE PERFORMED AT THIS PLACE OF SERVICE
4037	THE PROCEDURE CODE BILLED IS NOT ALLOWED FOR THE DIAGNOSIS CODE INDICATED ON THE CLAIM
4039	THIS DIAGNOSIS CODE CANNOT BE USED AS PRINCIPAL DIAGNOSIS
4040	PRIMARY DIAGNOSIS CODE NOT ON FILE FOR DATE OF SERVICE
4041	SECONDARY DIAGNOSIS CODE NOT ON FILE
4042	THIRD DIAGNOSIS CODE NOT ON FILE
4043	FOURTH DIAGNOSIS CODE NOT ON FILE

4044	PROCEDURE CODE NOT COMPENSABLE FOR PROVIDER TYPE/SPECIALTY
4045	PROVIDER TYPE/SPECIALTY CODE/PROCEDURE CODE/MODIFIER INVALID
4046	PROVIDER TYPE/SPECIALTY CODE/PLACE OF SERVICE COMBINATION IS INVALID
4047	FIFTH DIAGNOSIS CODE NOT ON FILE
4048	SIXTH DIAGNOSIS CODE NOT ON FILE
4049	SEVENTH DIAGNOSIS CODE NOT ON FILE
4050	EIGHTH DIAGNOSIS CODE NOT ON FILE
4051	DIAGNOSIS CODE NOT ON FILE
4053	PRINCIPAL ICD PROCEDURE CODE NOT ON FILE OR NOT VALID FOR PROCEDURE DATE
4054	SECOND ICD PROCEDURE CODE NOT ACTIVE ON DATE OF SERVICE
4055	THIRD PROCEDURE CODE NOT ACTIVE FOR DATE OF SERVICE
4056	FOURTH PROCEDURE CODE NOT ACTIVE FOR DATE OF SERVICE
4057	FIFTH PROCEDURE CODE NOT ACTIVE FOR DATE OF SERVICE
4058	SIXTH PROCEDURE CODE NOT ACTIVE FOR DATE OF SERVICE
4059	REVENUE CODE NOT ON FILE
4061	FORM MA30 REQUIRED FOR HYSTERECTOMY PROCEDURE - DETAIL
4062	FORM MA30 REQUIRED FOR HYSTERECTOMY PROCEDURE - HEADER
4063	ICD PROCEDURE CODE/AGE RESTRICTION
4064	ICD PROCEDURE CODE BILLED IS INCONSISTENT WITH RECIPIENT'S GENDER
4066	ICD PROCEDURE CODE/DIAGNOSIS RESTRICTION
4067	NON-COVERED ICD PROCEDURE CODE
4070	CLAIM MUST BE BILLED BY THE HOME AND COMMUNITY SERVICES INFORMATION SYSTEM (HCSIS)
4071	BSC PROVIDER PROCEDURE MODIFIER DIAGNOIS RESTRICTION
4072	BSC PROVIDER PROCEDURE MODIFIER AUTISM RESTRICTION
4075	MISSING / INVALID TRANSACTION COUNT
4078	MISSING / INVALID OTHER COVERAGE CODE
4079	MISSING / INVALID ELIGIBILITY CLARIFICATION CODE
4080	PRILOSEC OTC EXCEED MAX QUANTITY. RECIPIENTS AGE GREATER THAN 14.
4081	PRIOR AUTHORIZATION (PA) REQUIRED FOR NON-PREFERRED PROTON PUMP INHIBITOR (PPI). RECIPIENTS AGE GREATER THAN 14.
4082	PRIOR AUTHORIZATION (PA) REQUIRED GREATER THAN 136 DAYS - HISTORY OF PROTON PUMP INHIBITOR (PPI). RECIPIENTS AGE GREATER THAN 14.
4083	PRIOR AUTHORIZATION (PA) REQUIRED GREATER THAN 136 OR GREATER THAN 204 DAYS - NO HISTORY OF PROTON PUMP INHIBITOR (PPI). RECIPIENTS AGE GREATER THAN 14.
4084	PRIOR AUTHORIZATION (PA) REQUIRED GREATER THAN 340 DAYS OR GREATER THAN 408 DAYS OF A PROTON PUMP INHIBITOR (PPI). RECIPIENTS AGE GREATER THAN 14.
4085	MAXIMUM DAILY DOSAGE EXCEEDED FOR ANTI-ULCER. BETWEEN AGE 22 AND 64.
4086	MISSING/INVALID LEVEL OF SERVICE
4087	PHARMACY NOT CONTRACTED WITH MANAGED CARE PLAN ON DATE OF SERVICE

4088	PRIOR AUTHORIZATION (PA) REQUIRED FOR MORE THAN THREE TABLETS OF OXYCONTIN PER DAY
4089	PRIOR AUTHORIZATION (PA) REQUIRED FOR MORE THAN TWO CONCURRENT STRENGTHS OF OXYCONTIN
4090	REFILL TOO SOON - OXYCONTIN CLAIM
4091	REFILL TOO SOON - ANTI-ULCER CLAIM
4092	ANTI-ULCER TAKEN FOR MORE THAN 90 DAYS REQUIRES PRIOR AUTHORIZATION
4093	PRILOSEC TEN MG EXCEED MAX QUANTITY
4094	MISSING/INVALID PRIOR AUTHORIZATION TYPE CODE
4096	MISSING/INVALID PRIOR AUTHORIZATION NUMBER SUBMITTED
4097	THE MODIFIER CODE IS NOT FOUND TO BE A PROCESSING MODIFIER
4099	DIAGNOSIS RELATED GROUP (DRG) IS NOT ON FILE OR NOT VALID FOR DATE OF SERVICE
4100	THERE IS NOT A PROVIDER SPECIFIC FEE FOR THE DATE OF SERVICE (DOS).
4101	BILLED AMOUNT LESS THAN ACA (AFFORDABLE CARE ACT) PRIMARY CARE FEE
4102	NO MARGINAL COST FACTOR FOR DATE OF SERVICE
4103	ACA (AFFORDABLE CARE ACT) PRIMARY CARE FEE ASSIGNED
4104	PH95 CO-PAY AMOUNT REDUCED DUE TO FINAL ALLOWED AMOUNT - HEADER
4105	PH95 CO-PAY AMOUNT REDUCED DUE TO FINAL ALLOWED AMOUNT - DETAIL
4106	BILLED AMOUNT IS LESS THAN ACA (AFFORDABLE CARE ACT) PRIMARY CARE FEE FOR 2009+ SERVICE.
4107	ACA (AFFORDABLE CARE ACT) PRIMARY CARE FEE ASSIGNED FOR 2009+ SERVICEC
4108	REVIEW DETAIL FOR CURRENT/HISTORICAL DIAGNOSES
4109	THE PATIENT LOCATION CODE IS MISSING OR NOT VALID
4110	CLAIM REQUIRES THE OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (OMHSAS) REVIEW
4111	INVALID PATIENT RELATIONSHIP CODE
4112	INVALID PATIENT ID QUALIFIER
4113	INVALID PATIENT RESIDENCE CODE
4114	INVALID PATIENT GENDER CODE
4115	INVALID PATIENT STATE ADDRESS CODE
4116	PATIENT ID IS REQUIRED
4117	SUBMIT ENCOUNTER 837I DRUG ON OR AFTER 10/01/2013
4118	MISSING PATIENT LAST NAME
4120	THIS PROCEDURE CODE REQUIRES A VALID TOOTH QUADRANT
4121	SERVICE PROGRAM NOT ELIGIBLE FOR INPATIENT / LONG TERM CARE (LTC) SERVICES, Confirm beneficiary number on claim = ten digits
4122	MEDICAL ASSISTANCE / SPECIAL PHARMACEUTICAL BENEFIT PROGRAM (SPBP) DUAL ELIGIBLE OR SPECIAL PHARMACEUTICAL BENEFIT PROGRAM (SPBP) COVERAGE END DATED
4123	MEDICAL ASSISTANCE / SPECIAL PHARMACEUTICAL BENEFIT PROGRAM (SPBP) DUAL COVERAGE - SPECIAL PHARMACEUTICAL BENEFIT PROGRAM (SPBP) COVERED ONLY
4124	THERE IS NO SPECIAL PHARMACEUTICAL BENEFIT PROGRAM (SPBP) ELIGIBILITY ON FILE FOR THE DATE OF SERVICE (DOS)
4130	MEDICARE AMOUNT IS LESS THAN THE DIAGNOSIS RELATED GROUP (DRG) AMOUNT

4141	VERIFY PART B PREMIUM ONLY
4142	INVALID PRODUCT QUALIFIER FOR COMPOUND
4143	MANAGED CARE ORGANIZATION (MCO) PLAN MUST BE CERTIFIED FOR ENCOUNTER 837I DRUG
4144	THE NATIONAL DRUG CODE (NDC) NOT COVERED ON DATE OF SERVICE FOR COMPOUND
4147	RECIPIENT ID NUMBER IS NOT ON THE PRIOR AUTHORIZATION DATABASE
4150	DRUG CLAIM DATE OF SERVICE (DOS) AFTER BILLING REVALIDATION DATE
4151	DRUG CLAIM DATE OF SERVICE (DOS) AFTER PRESCRIBER REVALIDATION DATE
4152	EMERGENCY SUPPLY LIMIT EXCEEDED (ONE PER DRUG PER MONTH)
4153	DRUG CODE FOR A PRE-NATAL VITAMIN WITH NO PREGNANCY INDICATOR
4154	EMERGENCY QUANTITY CANNOT EXCEED A FIVE-DAY SUPPLY
4155	MAXIMUM QUANTITY EXCEEDED ON AN EMERGENCY SUPPLY
4156	RECIPIENT ONLY ELIGIBLE FOR BIRTH CONTROL DRUGS
4157	PRIOR AUTHORIZATION IS REQUIRED FOR EXCEPTIONS TO THE MONTHLY PRESCRIPTION GA (General Assistance) LIMIT
4158	REVERSAL INFORMATION DOES NOT MATCH A PREVIOUSLY APPROVED CLAIM
4159	THIS CLAIM HAS ALREADY BEEN REVERSED
4160	MORE THAN ONE CLAIM HAS BEEN APPROVED WHEN TRYING TO REVERSE A CLAIM
4164	THERE IS MORE THAN ONE REVENUE CODE EQUAL TO '0001' ON YOUR INPATIENT INVOICE.
4165	CLAIM IS SUSPENDED TO VERIFY ELIGIBILITY FOR THESE SERVICES - DETAIL
4166	YOUR CLAIM IS SUSPENDED TO VERIFY ELIGIBILITY FOR THESE SERVICES. - DETAIL
4167	THE DIAGNOSIS RELATED GROUP (DRG) THAT YOUR CLAIM IS GROUPED INTO IS NOT COMPENSABLE
4169	THE MODIFIER IS NOT COMPENSABLE
4170	THIS RECIPIENT'S HEALTHCARE BENEFITS PACKAGE DOES NOT COVER MENTAL HEALTH INTENSIVE CASE MANAGEMENT, MENTAL RETARDATION SERVICE MANAGEMENT, CRISIS INTERVENTION SERVICES, RATE EXCEPTION - COMMUNITY SUPPORT SERVICES-MENTAL HEALTH (CSS-MH), OR BELOW FEE SCHEDULE - COMMUNITY SUPPORT SERVICES-MENTAL HEALTH (CSS-MH). RECIPIENT AGE SHOULD BE GREATER THAN 20 AND LESS THAN 65.
4171	THE DEPARTMENT HAS SUSPENDED YOUR CLAIM TO VERIFY YOUR USUAL CHARGE.
4172	SUSPENDED TO VERIFY AMOUNT APPROVED LESS CO-PAY APPROVED
4173	BRAND DRUG MEDICALLY NECESSARY
4174	THIS CLAIM REQUIRES MANUAL REVIEW TO DETERMINE THE PROVIDER'S SPECIFIC FEE ON THE DEPARTMENT'S RECORDS.
4175	AN INPATIENT ADMISSION STRADDLES A NEW RATE CHANGE. PLEASE RESUBMIT ON SEPARATE INVOICES.
4176	YOUR INVOICE HAS BEEN SUSPENDED FOR MANUAL REVIEW TO DETERMINE THE ALLOWABLE AMOUNT OF PAYMENT.
4177	INTERIM PRICING WAS APPLIED TO THIS CLAIM - PAYMENT FOR THIS CLAIM WAS LIMITED TO THE INTERIM BILL CEILING.
4178	INVALID BIN NUMBER
4179	INVALID NATIONAL COUNCIL OF PRESCRIPTION DRUG PROGRAM (NCPDP) VERSION NUMBER
4180	INVALID TRANSACTION CODE
4181	INVALID PROCESSOR NUMBER
4182	BRAND MULTI-SOURCE DRUG WITHOUT BRAND MEDICALLY NECESSARY (BMN) ASSIGNMENT CODE
4183	SERVICE PROVIDER IDENTIFICATION QUALIFIER IS INVALID

4184	INVALID SOFTWARE VENDOR CERTIFICATION IDENTIFICATION
4185	INVALID PATIENT SEGMENT IDENTIFIER
4186	INVALID INSURANCE SEGMENT IDENTIFIER
4187	INVALID CLAIM SEGMENT IDENTIFIER
4188	INVALID PHARMACY (RX) / SERVICE REFERENCE NUMBER QUALIFIER
4189	INVALID PRODUCT / SERVICE IDENTIFICATION QUALIFIER
4190	INVALID COMPOUND CODE
4191	INVALID SUBMISSION CLARIFICATION CODE
4192	INVALID UNIT OF MEASURE
4193	INVALID PRESCRIBER SEGMENT IDENTIFIER
4194	INVALID PRESCRIBER IDENTIFICATION QUALIFIER
4195	INVALID COORDINATION OF BUSINESS (COB) / OTHER PAYER SEGMENT IDENTIFIER
4196	INVALID COORDINATION OF BUSINESS (COB) / OTHER PAYER COUNT
4197	COORDINATION OF BUSINESS (COB) / OTHER PAYER COUNT DOES NOT MATCH ACTUAL NUMBER OF SEGMENTS
4198	MISSING / INVALID OTHER PAYER COVERAGE TYPE
4199	INVALID OTHER PAYER IDENTIFICATION (ID) NUMBER QUALIFIER
4200	CLAIM PRICED AT ZERO
4201	CLAIM CANNOT HAVE BOTH COUNTY AND TREASURY PAID DETAILS
4202	THIRD PARTY LIABILITY (TPL) BYPASS BRAND MEDICAL NECESSARY DRUG
4203	DENIAL MODIFIER FOR NON COVERED SERVICES
4204	SUSPEND FOR MANUAL PRICING - INPATIENT/LONG TERM CARE (LTC) - (INSTITUTIONLA CLAIMS)
4205	RENDERING PROVIDER NOT DIABETES TRAINING & EDUCATION (DTE) CERTIFIED
4206	DATE OF SERVICE (DOS) NOT WITHIN THE DIABETES TRAINING & EDUCATION (DTE) CERTIFICATION EFFECTIVE DATES
4207	CLINICAL LABORATORY IMPROVEMENT ACT (CLIA), OF 1988, NUMBER NOT ON FILE FOR DATES OF SERVICE BILLED
4208	INVALID CLINICAL LABORATORY IMPROVEMENT ACT (CLIA), OF 1988, CERTIFICATION / PROCEDURE CODE COMBINATION
4209	NO PRICING SEGMENT FOR PROCEDURE / MODIFIER COMBINATION
4210	THIS PROCEDURE HAS BEEN IDENTIFIED AS CLINICAL LABORATORY IMPROVEMENT ACT (CLIA), OF 1988, RELATED AND CLAIM IS SUSPENDED FOR REVIEW
4211	TOOTH NUMBER / PROCEDURE CODE COMBINATION INVALID
4212	NO ADDITIONAL PAYMENT IS DUE FROM MEDICAL ASSISTANCE
4213	INVALID PHARMACY SERVICE TYPE
4214	MISSING INGREDIENT COST SUBMITTED
4215	MISSING GROSS AMOUNT DUE
4216	DUPLICATE OTHER PAYER COVERAGE TYPE
4217	NCPDP D.0 FUTURE ESC
4218	INVALID MEASUREMENT DIMENSION SUBMITTED
4219	INVALID MEASUREMENT UNIT SUBMITTED

4220	TECHNICAL/TOTAL COMPONENT IS NOT COMPENSIBLE FOR PROVIDER TYPE 31 IN PLACE OF SERVICE BILLED
4221	PROCEDURE REQUIRES MEDICAL REVIEW FOR RECIPIENT AGE
4222	PROCEDURE CODE REQUIRES MEDICAL REVIEW FOR MEDICAL ASSISTANCE LIMITATIONS
4223	PROCEDURE CODE REQUIRES MEDICAL REVIEW FOR RECIPIENT AGE
4224	UNITS OF SERVICE ARE LESS THAN PROCEDURE CODE ALLOWED UNITS
4225	AT LEAST ONE ACCOMMODATION REVENUE CODE REQUIRED
4227	INACTIVE ESC
4228	ANESTHESIA MODIFIER IS INVALID OR MISSING
4229	THIS DIAGNOSIS REQUIRES MEDICAL REVIEW FOR RECIPIENT AGE
4230	MEDICARE DEDUCTIBLE BILLED IS GREATER THAN MAXIMUM
4231	PROCEDURE MUST BE BILLED DIRECTLY TO MEDICAL ASSISTANCE
4232	EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SCREEN MUST HAVE ASSESSMENT
4233	CYSTOURETHROSCOPY DIAGNOSIS RESTRICTIONS
4236	INVALID USE OF EXTERNAL CAUSE DIAGNOSIS CODE
4237	RESERVED FOR NON EMERGENCY AMBULANCE TRANSPORTS
4238	AMBULANCE SERVICES ORIGIN TO DESTINATION NOT IN SCOPE
4240	THIS PROCEDURE MUST BE BILLED SEPARATELY FOR EACH DATE
4241	INVALID OTHER PAYER PATIENT RESPONSIBILITY AMOUNT QUALIFIER
4242	MISSING DISPENSING FEE SUBMITTED
4243	MISSING OTHER PAYER INTERNAL CONTROL NUMBER
4244	DISPENSING FEE RECORD NOT FOUND
4245	FOURTH MODIFIER INVALID
4248	MODIFIER FOR THE PROCEDURE CODE BILLED IS MISSING OR INVALID
4249	INVALID USE OF MODIFIER
4250	MODIFIER(S) NOT COMPENSABLE FOR THIS PROCEDURE CODE
4251	MORE THAN ONE PRICING MODIFIER IS PRESENT THEREFORE THE CLAIM CANNOT BE PRICED
4252	BILLING PROVIDER TYPE NOT ELIGIBLE TO RENDER PROCEDURE CODE
4253	ADMISSION CERTIFICATION OR DAY OUTLIER NOT ACCEPTABLE
4254	DAY OUTLIER BILLED ON INTERIM BILL
4255	YOU HAVE REQUESTED AN OUTLIER, BUT AN OUTLIER WAS NOT IDENTIFIED BY THE DEPARTMENT.
4256	THE DEPARTMENT HAS IDENTIFIED A COST OUTLIER.
4257	THIS CLAIM REQUIRES MANUAL REVIEW TO VERIFY THE AMOUNT APPROVED DETERMINED BY THE DEPARTMENT.
4258	YOUR CLAIM HAS SUSPENDED FOR MANUAL REVIEW FOR DIAGNOSIS RELATED GROUP (DRG) NUMBER 424
4259	DIAGNOSIS RELATED GROUP (DRG) NUMBER 469 WAS ASSIGNED TO YOUR INVOICE; THEREFORE, IT CANNOT BE PAID.
4260	DIAGNOSIS RELATED GROUP (DRG) NUMBER 470 WAS ASSIGNED TO YOUR INVOICE; THEREFORE, IT CANNOT BE PAID.
4261	YOU ARE ELIGIBLE FOR AN OUTLIER.
4262	SINCE YOU DO NOT HAVE A LICENSED DRUG AND ALCOHOL UNIT, YOU ARE ONLY ALLOWED A MAXIMUM OF TWO (2) DAYS PAYMENT.

4264	DIAGNOSIS RELATED GROUP (DRG) TRANSFER AMOUNT IS LESS THAN DIAGNOSIS RELATED GROUP (DRG) ADJUSTMENT AMOUNT
4265	POSSIBILITY OF DAY OUTLIER. IF OUTLIER REQUESTED, THERE WILL BE A REVIEW. IF NOT REQUESTED, CLAIM WAS PRICED BY DIAGNOSIS RELATED GROUP (DRG). NO VALID PA.
4266	DAILY DOSAGE EXCEEDS LIMIT FOR EMERGENCY CLAIM
4267	DAILY DOSAGE EXCEEDED FOR NON-EMERGENCY CLAIM
4268	DAILY DOSAGE EXCEEDS LIMIT BYPASSED DUE THIRD PARTY LIABILITY (TPL)
4270	DRUG CANNOT BE BILLED BY A FAMILY PLANNING CLINIC
4271	CLAIMS ADJUSTMENT REASON CODE MISSING OR INVALID - HEADER
4272	CLAIMS ADJUSTMENT REASON CODE MISSING OR INVALID - DETAIL
4273	MANAGED CARE ORGANIZATION (MCO) PAID AMOUNT DOES NOT AGREE WITH CLAIM ADJUSTMENT REASON CODE - HEADER
4274	MANAGED CARE ORGANIZATION (MCO) PAID AMOUNT DOES NOT AGREE WITH CLAIM ADJUSTMENT REASON CODE - DETAIL
4275	CN1 TYPE/CLAIM ADJUSTMENT REASON CODE DOES NOT AGREE WITH PAID AMOUNT - HEADER
4276	CN1 TYPE/CLAIM ADJUSTMENT REASON CODE DOES NOT AGREE WITH PAID AMOUNT - HEADER
4277	PROVIDER TYPE DOES NOT AGREE WITH CONTRACT TYPE
4278	CN1 TYPE/CLAIM ADJUSTMENT REASON CODE DOES NOT AGREE WITH PAID AMOUNT - DETAIL
4279	CLAIM TYPE NOT COMPATIBLE WITH CONTRACT TYPE
4280	PHARMACY OTHER PAYER REJECTED CODE INVALID FOR MANAGED CARE ORGANIZATION (MCO) PHARMACY
4281	THE MANAGED CARE ORGANIZATION (MCO) PAID AMOUNT DOES NOT AGREE WITH THE OTHER PAYER REJECTED CODE
4282	CLAIM TYPE NOT COMPATIBLE WITH CONTRACT TYPE
4283	CONTRACT TYPE NOT VALID FOR MANAGED CARE ORGANIZATION (MCO) - HEADER
4284	CONTRACT TYPE NOT VALID FOR MANAGED CARE ORGANIZATION (MCO) - DETAIL
4285	APR DRG 740 - MANUAL REVIEW REQUIRED
4286	APR DRG 956 - UNGROUPABLE
4287	APR DRG 955 - UNGROUPABLE
4288	PROVIDER BASE APR DRG RATE MISSING OR FOUND VALUE ZERO
4289	APR DRG NONCOMPENSABLE/ALOS AND/OR WEIGHT = 0
4290	PERCENTAGE/THRESHOLD MISSING FOR APR DRG
4291	LOW COST OUTLIER PRICING
4292	HIGH COST OUTLIER PRICING
4293	APR DRG 956 - DIAGNOSIS CANNOT BE USED AS PRIMARY
4294	APR DRG 956 - RECORD DOES NOT MEET ANY DRG CRITERIA
4295	APR DRG 956 - INVALID DISCHARGE STATUS
4296	APR DRG 956 - INVALID PRIMARY DIAGNOSIS
4297	APR DRG 956 - NEWBORN AGE/BIRTH WEIGHT CONFLICT
4298	APR DRG NOT ON FILE OR END DATED
4299	MDC 14 WITH NON-MATERNITY APR DRGS (All Patient Refined - Diagnosis Related Groups)
4300	OTHER PAYER ID IS MISSING OF INVALID

4301	THIS MANAGED CARE ORGANIZATION (MCO) IS NOT ACTIVE
4302	THIS MANAGED CARE ORGANIZATION (MCO) IS NOT ON FILE
4303	OTHER PAYER DATE MISSING
4304	OTHER PAYER DATE INVALID
4305	OTHER PAYER COUNT IS INVALID
4306	OTHER PAYER PAID AMOUNT QUALIFIER IS INVALID
4307	OTHER PAYER PAID AMOUNT QUALIFIER FOR PRIMARY PAYER IS INVALID
4308	OTHER PAYER PAID AMOUNT QUALIFIER FOR SECONDARY PAYER IS INVALID
4309	OTHER PAYER PAID AMOUNT FOR PRIMARY PAYER ENCOUNTER IS INVALID
4310	OTHER PAYER PAID AMOUNT FOR SECONDARY PAYER ENCOUNTER IS INVALID
4311	OTHER PAYER REJECT COUNT IS INVALID
4312	OTHER PAYER REJECT CODE IS INVALID
4313	DRUG UTILIZATION REVIEW (DUR) / PROSPECTIVE PAYMENT SYSTEM (PPS) SEGMENT IDENTIFIER IS INVALID
4314	DRUG UTILIZATION REVIEW (DUR) / PROSPECTIVE PAYMENT SYSTEM (PPS) CODE COUNTER IS INVALID
4315	REASON FOR SERVICE CODE IS INVALID
4316	PROFESSIONAL SERVICE CODE IS INVALID
4317	RESULT OF SERVICE CODE IS MISSING OR INVALID
4318	PRICEING SEGMENT IDENTIFIER IS INVALID
4319	INGREDIENT COST SUBMITTED IS INVALID
4320	BASIS OF COST DETERMINATION IS INVALID
4321	COMPOUND SEGMENT IDENTIFIER IS INVALID
4322	COMPOUND DISPENSING UNIT FORM INDICATOR IS INVALID
4323	COMPOUND ROUTE OF ADMINISTRATION IS INVALID
4324	COMPOUND INGREDIENT COUNT IS MISSING OR INVALID
4325	OVER MAXIMUM COMPOUND INGREDIENT COUNT
4326	SUBMITTED COMPOUND INGREDIENT COUNT DOES NOT MATCH ACTUAL
4327	COMPOUND PRODUCT IDENTIFICATION QUALIFIER IS INVALID
4328	COMPOUND INGREDIENT DRUG COST IS INVALID
4329	COMPOUND INGREDIENT BASIS OF COST DETERMINATION IS INVALID
4330	CLINICAL SEGMENT IDENTIFIER IS INVALID
4331	DIAGNOSIS CODE COUNT IS INVALID
4332	SUBMITTED DIAGNOSIS CODE COUNT DOES NOT MATCH ACTUAL
4333	DIAGNOSIS CODE QUALIFIER IS INVALID
4334	DIAGNOSIS CODE IS INVALID
4336	COMPOUND DOSAGE FORM IS INVALID
4337	INVALID OTHER PAYER COUNT - ENCOUNTER
4338	INVALID OTHER PAYER COVERAGE TYPE - ENCOUNTER

4339	NATIONAL DRUG CODE (NDC) NOT COVERED IN A NON COMPOUND CLAIM
4340	NATIONAL DRUG CODE (NDC) REQUIRES MANUAL REVIEW UNLESS ELIGIBILITY CLARIFICATION CODE
4341	COMPOUND MUST CONTAIN AT LEAST TWO INGREDIENTS
4342	NO EMERGENCY SUPPLIES ALLOWED FOR THIS DRUG
4343	ERECTILE DYSFUNCTION (ED) DRUG NOT COVERED EFFECTIVE 3/1/2006
4345	DRUG CAN NOT BE BILLED FOR FAMILY PLANNING SERVICES - SELECT PLAN FOR WOMEN
4346	CLAIM MUST CONTAIN MODIFIER 'FP' OR FAMILY PLANNING 'DX'
4347	GENDER INAPPROPRIATE FOR SELECT PLAN
4348	CLAIM CONTAINS ICD-9 AND ICD-10 DIAG CODE QUALIFIERS
4349	INVALID DIAGNOSIS CODE QUALIFIER FOR DISCHARGE DATE
4350	INVALID DIAGNOSIS CODE QUALIFIER FOR DETAIL DOS (DATE OF SERVICE)
4351	CLAIM CONTAINS ICD-9 AND ICD-10 PROCEDURE CODE QUALIFIERS
4352	INVALID PROCEDURE CODE QUALIFIER FOR DOS (DATE OF SERVICE)
4353	DUPLICATE PAYER RESPONSIBILITY SEQUENCE NUMBER
4354	NORMAL NEWBORN
4355	PHYSICIAN MAY NOT BILL SEPARATELY FOR 01/017 ER SERVICE
4356	FACILITY NUMBER IS INVALID
4357	ICD-10 CODES CANNOT BE SUBMITTED PRIOR TO DATE OF SERVICE 10/01/2015
4358	ICD-9 CODESCANNOT BE SUBMITTED AFTER DATE OF SERVICE 09/30/2015
4359	ICD-9/ICD-10 CODES CANNOT BE SUBMITTED ON THE SAME CLAIM
4360	ACAP SERVICES SUSPENDED FOR REVIEW
4361	SERVICES NOT COVERED FOR THIS PROGRAM
4362	RECIPIENT NOT COVERED FOR PROGRAM
4400	DATE OF SERVICE (DOS) MUST BE WITHIN 30 DAYS OF DISCHARGE DATE (PSYCHOLOGICAL ADMISSION) - DETAIL
4401	DATE OF SERVICE (DOS) MUST BE WITHIN 30 DAYS OF DISCHARGE DATE (PSYCHOLOGICAL ADMISSION) - DETAIL
4402	UNITS MUST BE BILLED IN INCREMENTS OF FOUR
4403	UNITS MUST BE BILLED IN TWO UNIT INCREMENTS
4404	DIAGNOSIS RESTRICTIONS FOR CLOZAPINE SUPPORT SERVICES
4405	SUMMER THERAPEUTIC ACTIVITIES PROGRAM (STAP) PAYMENTS LONG TERM LIVING (LTD) TO DATE OF SERVICE (DOS) 06/01 THROUGH 09/30
4408	DATE OF SERVICE(DOS) IS NOT EQUAL TO ADMISSION DATE
4409	DATE OF SERVICE (DOS) NOT WITHIN 30 DAYS OF THE DISCHARGE DATE
4410	ADMISSION DATE IS REQUIRED
4411	DISCHARGE DATE IS REQUIRED
4412	DATE OF SERVICE (DOS) NOT WITHIN ADMISSION OR DISCHARGE DATE
4413	EMERGENCY SUPPLY BYPASS OF AHF (ANTIHEMOPILIA FACTOR) DRUG
4414	NON-EMERGENCY SUPPLY BYPASS OF THE AHF (ANTIHEMOPILIA FACTOR) DRUG

4415	VALIDATE NUMBER OF UNITS BILLED AND BILLED AMOUNT FOR EMERGENCY SUPPLY
4416	VALIDATE THE NUMBER OF UNITS BILLED AND THE BILLED AMOUNT
4417	UNIT OF MEASURE DOES NOT MATCH DRUG FORM
4418	PRODUCT AND DRUG FORM COMBINATION BYPASS OF ESC 4415
4419	PART B DRUG AND THIRD PARTY LIABILITY (TPL) AMOUNT COMBINATION BYPASS OF 4415
4420	PRODUCT AND DRUG FORM COMBINATION BYPASS OF ESC 4416
4421	PART B DRUG AND THIRD PARTY LIABILITY (TPL) AMOUNT COMBINATION BYPASS OF 4416
4422	COMPOUND CLAIM REQUIRES PRIOR AUTHORIZATION
4423	COMPOUND CLAIM BYPASS FOR DOLLAR THRESHOLD
4424	COMPOUND CLAIM BYPASS FOR GC4
4425	COMPOUND CLAIM BYPASS FOR AGE RESTRICTION
4426	COMPOUND CLAIM BYPASS FOR OTHER COVERAGE CODE (OCC) AND THIRD PARTY LIABILITY (TPL)
4427	COMPOUND CLAIM BYPASS FOR EMERGENCY SUPPLY
4486	CLAIM CONTAINS VALUE CODES FC AND 66
4487	VALUE CODE 54 AMOUNT SUSPENDED FOR MANUAL REVIEW
4488	VALUE CODE 80 AMOUNT SUSPENDED FOR MANUAL REVIEW
4489	VALUE CODE 81 AMOUNT SUSPENDED FOR MANUAL REVIEW
4490	VALUE CODE 82 AMOUNT SUSPENDED FOR MANUAL REVIEW
4491	VALUE CODE 83 AMOUNT SUSPENDED FOR MANUAL REVIEW
4503	THIS CLAIM REQUIRES MANUAL REVIEW TO VERIFY THE NUMBER OF DAYS BETWEEN THE DATE THE RECIPIENT SIGNED THE STERILIZATION CONSENT FORM (MA-31) AND THE DATE OF SERVICE FOR THE STERILIZATION PROCEDURE
4504	THIS CLAIM REQUIRES MANUAL REVIEW TO DETERMINE IF THE INTERPRETER AREA ON THE STERILIZATION CONSENT FORM (MA-31) WAS COMPLETED.
4505	THIS CLAIM REQUIRES MANUAL REVIEW TO DETERMINE THE REASON THE HYSTERECTOMY WAS PERFORMED.
4506	THIS CLAIM REQUIRES MANUAL REVIEW TO DETERMINE THE TYPE OF ABORTION IDENTIFIED ON THE PHYSICIAN CERTIFICATION FOR AN ABORTION (MA-3 FORM)
4507	THE TIME NECESSARY BETWEEN THE DATE OF INFORMED CONSENT AND THE DATE OF STERILIZATION IS NOT WITHIN THE REQUIRED LIMITS AS ESTABLISHED BY MEDICAL ASSISTANCE REGULATIONS.
4511	STERILIZATION CONSENT FORM REQUIRED -DETAIL
4512	STERILIZATION CONSENT FORM REQUIRED -HEADER
4513	MILEAGE PROCEDURE CODE REQUIRES ATTACHMENT
4515	PROCEDURE CODE/MODIFIER VERSUS AGE RESTRICTION
4516	PROCEDURE CODE/MODIFIER VERSUS GENDER RESTRICTION
4518	UNITS BILLED EXCEED ALLOWABLE FOR PROCEDURE CODE/MODIFIER
4519	MODIFIER 'HD' REQUIRES HEALTHY BEGINNINGS ENROLLMENT
4521	MODIFIER 'HD' REQUIRES PREGNANCY INDICATOR
4522	BILATERAL PROCEDURE CODES REQUIRES MEDICAL REVIEW
4523	UNITS ARE LESS THAN MINIMUM FOR PROCEDURE CODE AND MODIFIER

4524	SPECIALTY ENROLLMENT REQUIRED FOR NURSE FAMILY PARTNERSHIP
4525	PREGNANCY INDICATOR MUST BE USED WITH MODIFIER 'SK'
4526	NURSE FAMILY PARTNERSHIP - GROUP MEDICAL ASSISTANCE IDENTIFICATION NUMBER (MA ID) REQUIRED
4527	RECIPIENT AGE IS INAPPROPRIATE FOR SERVICE BILLED
4528	CHILDHOOD NUTRITION AND WEIGHT MANAGEMENT SERVICES (CNWMS) INITIAL ASSESSMENT NOT PAID IN HISTORY
4529	BASIC LIFE SUPPORT (BLS) EMERGENCY NOT PAID IN HISTORY SAME DATE OF SERVICE (DOS) - Different Provider
4530	BASIC LIFE SUPPORT (BLS) EMERGENCY NOT PAID IN HISTORY SAME DATE OF SERVICE (DOS) - Same Provider
5000	DETAIL IS A SUSPECTED DUPLICATE - MODIFIER
5001	THIS INVOICE CLAIM LINE IS A DUPLICATE OF A PREVIOUSLY PAID CLAIM.
5002	THE DEPARTMENT'S RECORDS INDICATE THAT THIS DRUG CLAIM LINE HAS BEEN PREVIOUSLY PAID FOR THIS RECIPIENT.
5003	THIS INVOICE CLAIM LINE IS A DUPLICATE OF ONE PAID PREVIOUSLY BY THE DEPARTMENT.
5004	THIS CLAIM IS A DUPLICATE OF A PREVIOUSLY PAID CLAIM. (HEADER)
5005	THIS CLAIM IS A GENERIC DUPLICATE OF A DRUG CLAIM PREVIOUSLY SUBMITTED
5006	THE DEPARTMENT'S RECORDS INDICATE THAT THE MAXIMUM NUMBER OF REFILLS ALLOWED HAS BEEN EXCEEDED FOR THIS PRESCRIPTION.
5007	THIS IS A DUPLICATE SERVICE ACCORDING TO THE DEPARTMENT'S RECORDS. YOU HAVE BILLED FOR THE SAME PROCEDURE CODE, THE SAME RECIPIENT AND THE SAME DATE OF SERVICE AS A PREVIOUSLY PAID CLAIM. (DETAIL)
5008	YOUR CLAIM HAS SUSPENDED FOR REVIEW. THE PREVIOUS CLAIM MAY BE RECOVERED IF THIS IS A DUPLICATE.
5009	A VISIT AND A SURGICAL PROCEDURE HAVE BEEN BILLED ON THE SAME DATE OF SERVICE.
5010	TWO OR MORE SURGICAL/OBSTETRICAL PROCEDURES WITH THE SAME DATE OF SERVICE OR DURING THE SAME HOSPITALIZATION PERIOD HAVE BEEN BILLED. PAYMENT WILL BE REDUCED TO THE MAXIMUM ALLOWED ACCORDING TO MEDICAL ASSISTANCE REGULATION. REFER TO BULLETIN 01-91-01.
5011	YOU HAVE BILLED FOR MORE THAN ONE PROCEDURE FOR THE AMBULATORY SURGICAL CENTER (ASC) / SPECIAL PROCEDURE UNIT (SPU) SUPPORT COMPONENT FOR THIS RECIPIENT ON THE SAME DAY.
5012	THIS INVOICE CLAIM LINE IS A DUPLICATE FOR THIS RECIPIENT. THE CLAIM WAS PAID TO ANOTHER PROVIDER FOR THIS BILLING PERIOD.
5013	YOUR CLAIM HAS SUSPENDED (HELD) TO VERIFY THE REPAIR OF RENTED DURABLE MEDICAL EQUIPMENT. IF EQUIPMENT IS RENTED THE CLAIM WILL BE DENIED.
5014	THERE HAS BEEN MORE THAN ONE (1) DRUG AND ALCOHOL CLINIC VISIT BILLED FOR THE RECIPIENT ON THE SAME DATE OF SERVICE.
5015	PALLIATIVE EMERGENCY TREATMENT AND DENTAL SERVICES HAVE BEEN BILLED ON THE SAME DATE OF SERVICE.
5016	DUPLICATE CLAIM REFERENCE NUMBER (CRN) / INTERNAL CONTROL NUMBER (ICN) EXISTS ON THE DEPARTMENT'S RECORDS.
5017	THE DEPARTMENT'S RECORDS INDICATE WE HAVE ALREADY PAID FOR A BILATERAL PROCEDURE FOR THE PROCEDURE SHOWN ON YOUR CLAIM.
5018	THE DEPARTMENT'S RECORDS INDICATE THAT THIS EQUIPMENT HAS BEEN RENTED WITHIN THE PAST THREE (3) MONTHS. THIS INVOICE HAS BEEN SUSPENDED (HELD) FOR MANUAL REVIEW.
5019	DEPARTMENT PREVIOUSLY PAID A CLAIM(S) WITH THE SAME PLACE OF SERVICE REVIEW (PSR)
5020	THE DEPARTMENT WILL ONLY PAY FOR ONE MEDICAL / PSYCHIATRIC INPATIENT VISIT PER DAY FOR A RECIPIENT. THIS CLAIM EXCEEDS THAT LIMIT.
5021	SAME REVERSAL CRITERIA FOUND IN HISTORY
5022	DUPLICATE BILLING OF SURGICAL PROCEDURES

5023	DETAIL IS A SUSPECTED DUPLICATE – PROVIDER SERVICE LOCATION
5024	DUPLICATE BILLING OF BEHAVIORAL HEALTH (BH) ENCOUNTER
5025	BEHAVIORAL HEALTH (BH) CLAIM IS A DUPLICATE OF A PREVIOUSLY PAID CLAIM
5027	RENTAL PAYMENT LIMITED TO ONE PER CALENDAR MONTH ANY DAY OF THE MONTH.
5028	EMERGENCY ROOM SUPPORT COMPONENT OR EMERGENCY ROOM VISIT LIMIT ONE PER DAY PER PROVIDER
5029	ONE PHYSICAL THERAPY (PT)/OCCUPATIONAL THERAPY(OT)/SPEECH THERAPY (ST) PER DAY PER PROVIDER
5031	SUPER PRIOR AUTHORIZATION REQUIRED, MAXIMUM DAILY DOSE OF ED (ERECTILE DYSFUNCTION) PRESCRIPTION EXCEEDED
5032	SUPER PRIOR AUTHORIZATION REQUIRED, EARLY REFILL OF ED (ERECTILE DYSFUNCTION) PRESCRIPTION
5033	SUPER PRIOR AUTHORIZATION REQUIRED, DESIGN, DEVELOPMENT, AND IMPLEMENTATION (DDI) WITH AN ED (ERECTILE DYSFUNCTION) DRUG AND NITRATE
5034	SUPER PRIOR AUTHORIZATION REQUIRED, DESIGN, DEVELOPMENT, AND IMPLEMENTATION (DDI) WITH AN ED (ERECTILE DYSFUNCTION) DRUG AND ALPHA-BLOCKER
5035	SUPER PRIOR AUTHORIZATION REQUIRED, CURRENT ED (ERECTILE DYSFUNCTION) PRESCRIPTION NOT SAME AS LAST ED (ERECTILE DYSFUNCTION) PRESCRIPTION
5036	SUPER PRIOR AUTHORIZATION REQUIRED, ED (ERECTILE DYSFUNCTION) PRESCRIPTION FOR RECIPIENT LESS THAN 19 YEARS OLD
5037	SUPER PRIOR AUTHORIZATION REQUIRED, NO HISTORY OF ED (ERECTILE DYSFUNCTION) PRIOR AUTHORIZATION (PA) OR PROGRAM EXCEPTION (PE)
5038	LIMIT OF TWO PER MONTH ANY DAY OF THE MONTH
5039	DETAIL IS DUPLICATE - SERVICE LOCATION FOR CLAIM TYPES B AND M.
5040	PRIOR AUTHORIZATION REQUIRED, EARLY REFILL OF A COX II PRESCRIPTION (RX).
5041	PRIOR AUTHORIZATION REQUIRED, THERAPY OF A COX II PRESCRIPTION (RX) NOT CHANGED.
5042	PRIOR AUTHORIZATION IS REQUIRED IF NO HISTORY OF A COX II PRESCRIPTION (RX).
5043	MAXIMUM QUANTITY LIMIT EXCEEDED FOR ANTI-NAUSEA DRUG.
5046	EARLY REFILL OF COX-II
5047	COX-II DUPLICATIVE TOPICAL NSAID ANALGESIC
5048	COX-II CONCURRENT ANTI-COAGULANT. RECIPIENT AGE LESS THAN 70.
5049	ANTI-ULCER DRUG REQUIRES PRIOR AUTHORIZATION (PA).
5050	AN OUTPATIENT PROCEDURE CODE WAS BILLED AND THE DEPARTMENT'S RECORDS INDICATE THE RECIPIENT WAS AN INPATIENT ON THE DATE OF SERVICE ON THE INVOICE CLAIM LINE.
5051	THE REFILL ON THIS INVOICE CLAIM LINE IS OLDER THAN SIX MONTHS.
5052	YOUR CLAIM ADJUSTMENT PRIOR AUTHORIZATION / ADMISSION CERTIFICATION REVIEW NUMBER DOES NOT MATCH THE CLAIM P.A./A.C.R. NUMBER YOU ARE TRYING TO ADJUST.
5053	MEDICARE DEDUCTIBLE PLUS AMOUNT PAID EXCEEDS YEARLY MAXIMUM
5054	PLACE OF SERVICE REVIEW (PSR) NUMBER ON CLAIM WAS USED BY ANOTHER FACILITY
5055	YOU HAVE BILLED MORE THAN ONE PROCEDURE WITH THIS PLACE OF SERVICE REVIEW (PSR) NUMBER
5056	THE ORIGINAL INTERNAL CONTROL NUMBER (ICN)/CLAIM REFERENCE NUMBER (CRN) ON CLAIM ADJUSTMENT NOT ON DEPARTMENT RECORDS
5057	CLAIM LINE ON THIS ADJUSTMENT WAS PREVIOUSLY ADJUSTED
5058	UNITS OF SERVICE EXCEED THE UNITS OF SERVICE APPROVED BY DEPARTMENT

5059	THE CLAIM REFERENCE NUMBER (CRN) / INTERNAL CONTROL NUMBER (ICN) OF THE ADJUSTED CLAIM APPEARS ON THE REMITTANCE ADVICE (RA)
5060	UNITS OF SERVICE EXCEED UNITS OF SERVICE APPROVED BY DEPARTMENT
5061	THE PAYMENT FOR RETENTION SERVICES IS INCLUDED IN THE COMPLETED EIGHT QUARTERS OF ORTHODONTIC TREATMENT. IF YOU WERE PAID FOR THE RETENTION SERVICE, A CLAIM ADJUSTMENT WILL NEED TO BE SUBMITTED TO RETURN YOUR PAYMENT FOR THE RETENTION SERVICE.
5062	RETENTION SERVICES ARE NOT TO BE BILLED UNTIL YOU HAVE COMPLETED YOUR ORTHODONTIC TREATMENT. IF YOU WERE PAID FOR THE RETENTION SERVICE BEFORE YOU HAVE COMPLETED YOUR ORTHODONTIC TREATMENT, PLEASE SUBMIT A CLAIM ADJUSTMENT TO RETURN THE PAYMENT.
5063	YOU HAVE EXCEEDED THE MAXIMUM ALLOWABLE FEE FOR THIS RECIPIENT FOR ONE INPATIENT STAY.
5064	RETROACTIVE INCORRECT BILLING 8TH QUARTER ORTHODONTICS
5065	TWO OR MORE ANESTHESIA CODES BILLED
5066	PRIOR AUTHORIZATION (PA) REQUIRED FOR NON-STEROIDAL ANTI-INFLAMMATORY DRUGS
5067	TWO OR MORE SURGICAL PROCEDURES DURING SAME STAY
5068	TWO OR MORE ANESTHESIA PROCEDURES DURING SAME STAY
5070	ANTI-NAUSEA DRUGS LIMITED TO 21 PER MONTH
5071	ANTI-NAUSEA DRUGS LIMITED TO 14 PER MONTH
5072	ANTI-NAUSEA DRUGS LIMITED TO SEVEN PER MONTH
5073	ANTI-NAUSEA DRUGS LIMITED TO FIVE PER MONTH
5074	ANTI-NAUSEA DRUGS LIMITED TO TWO PER MONTH
5075	ANTI-NAUSEA DRUGS LIMITED TO 60 PER MONTH
5076	ANTI-NAUSEA DRUGS LIMITED TO 36 PER MONTH
5077	ANTI-NAUSEA DRUGS LIMITED TO 150 PER MONTH
5078	ANTI-NAUSEA DRUGS LIMITED TO SIX PER MONTH
5079	MAXIMUM 15 HOME HEALTH PROCEDURES IN A MONTH
5080	MANUAL REVIEW OF PRIOR AUTHORIZATION
5081	MANUAL REVIEW OF PROGRAM EXCEPTION
5082	MANUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS
5083	PROCEDURE CODE REQUIRES MANUAL PRICING
5090	PH95 CO-PAY IS MET/COPAY NOT APPLIED - HEADER
5091	PH95 CO-PAY IS MET/COPAY NOT APPLIED - DETAIL
5092	PH95 CO-PAY REDUCED DUE TO BALANCE REMAINING - HEADER
5093	PH95 CO-PAY REDUCED DUE TO BALANCE REMAINING - DETAIL
5094	MANAGED CARE ORGANIZATION (MCO) REPORTED CO-PAY MEETS PH95 ALLOCATION - HEADER
5095	MANAGED CARE ORGANIZATION (MCO) REPORTED CO-PAY MEETS PH95 ALLOCATION - DETAIL
5096	PH95 CO-PAYMENT EXCEEDED - HEADER
5097	PH95 CO-PAYMENT EXCEEDED - DETAIL
5100	PAYMENT OF THE INVOICE CLAIM LINE WOULD EXCEED THE MAXIMUM AMOUNT ALLOWED ANNUALLY FOR ANY COMBINATION OF DENTAL X-RAYS.

5101	PAYMENT OF THE INVOICE CLAIM LINE WOULD EXCEED THE MAXIMUM AMOUNT ALLOWED ANNUALLY FOR ANY COMBINATION OF DENTAL X-RAYS. (1999-2000)
5102	PAYMENT OF THE INVOICE CLAIM LINE WOULD EXCEED THE MAXIMUM AMOUNT ALLOWED ANNUALLY FOR ANY COMBINATION OF DENTAL X-RAYS. (PRE 1999)
5103	GENERAL ASSISTANCE (GA) RECIPIENT LIMITED TO SIX PRESCRIPTIONS PER MONTH
5104	PRESCRIPTION FOR GENERAL ASSISTANCE (GA) RECIPIENT EXCEEDED (FISCAL YEAR 1993)
5105	LIMIT ALLOWED EXCEEDED FOR PHARMACY CLAIMS
5106	THE LIMIT ALLOWED FOR THIS DENTAL RELINE PROCEDURE, ACCORDING TO MEDICAL ASSISTANCE REGULATIONS, HAS BEEN EXCEEDED. LIMIT ONE EVERY TWO YEARS.
5107	THE PROCEDURE CODE ON THE CURRENT CLAIM IS FOR A TOOTH WHICH THE DEPARTMENT'S RECORDS INDICATE HAS BEEN EXTRACTED.
5108	ATTENDANT CARE BILLING LIMIT AUDIT
5109	OUR RECORDS INDICATE YOU HAVE EXCEEDED THE BLOOD DEDUCTIBLE FOR THE CALENDAR YEAR.
5110	CO-PAY PAID VALUES EXCEEDS HOSPITAL STAY LIMIT
5111	CLAIM SUSPENDED TO DETERMINE AMOUNT OF CO-PAY FOR HOSPITAL
5112	THE ALLOWED LIMIT FOR PRACTITIONER OFFICE AND CLINIC VISITS, ACCORDING TO MEDICAL ASSISTANCE REGULATIONS, HAS BEEN EXCEEDED.
5113	THE LIMIT ALLOWED FOR HOME HEALTH VISITS, ACCORDING TO MEDICAL ASSISTANCE REGULATIONS, HAS BEEN EXCEEDED. MINIMUM AGE 21 (UNLIMITED FOR FIRST 28 DAYS; LIMITED TO 15 DAYS EVERY MONTH THEREAFTER.)
5114	THE RENTAL OF DURABLE MEDICAL EQUIPMENT (DME) HAS EXCEEDED THREE (3) MONTHS AND PRIOR AUTHORIZATION IS NOW REQUIRED. THE INVOICE HAS BEEN SUSPENDED (HELD) TO VERIFY THAT PRIOR AUTHORIZATION WAS OBTAINED.
5115	THE NUMBER OF PSYCHOTHERAPY PROCEDURES PERFORMED BY PSYCHIATRIC CLINICS FOR THIS RECIPIENT HAS EXCEEDED THE MAXIMUM AMOUNT ALLOWED PER MONTH BY MEDICAL ASSISTANCE REGULATIONS.
5116	THE MAXIMUM AMOUNT PAYABLE PER YEAR (EIGHTY DOLLARS) FOR PSYCHOLOGICAL / INTELLECTUAL EVALUATION HAS BEEN EXCEEDED FOR THIS RECIPIENT ACCORDING TO MEDICAL ASSISTANCE REGULATIONS.
5117	THE NUMBER OF PSYCHOTHERAPY PROCEDURES PERFORMED BY THE DRUG AND ALCOHOL CLINICS FOR THIS RECIPIENT HAS EXCEEDED THE MAXIMUM AMOUNT ALLOWED PER MONTH BY MEDICAL ASSISTANCE REGULATIONS.
5118	BILLED EXCEEDS LIMIT OF LONG TERM CARE (LTC) HOSPITAL BED HOLD DAYS (15) PER HOSPITALIZATION PERIOD.
5119	THE NUMBER OF INTERMEDIATE LONG TERM CARE (LTC) LEAVE DAYS (THE DAYS FOR WHICH A FACILITY HAS RESERVED THE RECIPIENT'S BED WHILE HE/SHE IS ON THERAPEUTIC LEAVE) FOR THIS RECIPIENT EXCEEDS THE MAXIMUM ALLOWED PER YEAR BY MEDICAL ASSISTANCE REGULATIONS.
5120	THE NUMBER OF INTERMEDIATE LONG TERM CARE (LTC) LEAVE DAYS (THE DAYS FOR WHICH A FACILITY HAS RESERVED THE RECIPIENT'S BED WHILE HE/SHE IS ON THERAPEUTIC LEAVE) FOR THIS RECIPIENT EXCEEDS THE MAXIMUM ALLOWED PER YEAR BY MEDICAL ASSISTANCE REGULATIONS. (ICF/MR)
5121	THE LIMIT ALLOWED, GENERAL ASSISTANCE (GA), FOR DRUG AND ALCOHOL INPATIENT VISITS, ACCORDING TO MEDICAL ASSISTANCE REGULATIONS, HAS BEEN EXCEEDED. MINIMUM AGE 21
5122	THE LIMIT ALLOWED FOR MEDICAL REHAB INPATIENT VISITS, ACCORDING TO MEDICAL ASSISTANCE REGULATIONS, HAS BEEN EXCEEDED.
5123	PAYMENT OF THE INVOICE CLAIM LINE WOULD EXCEED THE MAXIMUM AMOUNT ALLOWED PER TOOTH PER DAY FOR DENTAL RESTORATIONS.
5124	NUMBER OF LEAVE DAYS FOR RECIPIENT EXCEEDS MAXIMUM ALLOWED
5125	ONE DISPENSING FEE ALLOWED PER 25 DAYS FOR LONG TERM CARE RECIPIENT
5126	THE LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED.

5127	YOU HAVE BILLED MORE THAN ONE CONSULTATION FOR THE SAME RECIPIENT DURING THE SAME HOSPITALIZATION PERIOD.
5128	THE DEPARTMENT WILL ONLY PAY FOR ONE INITIAL MEDICAL / PSYCHIATRIC INPATIENT VISIT OR ONE ATTENDANCE AT A DELIVERY DURING THE SAME PERIOD OF HOSPITALIZATION.
5129	THE DEPARTMENT WILL PAY FOR ONLY TWO CONSULTATIONS PER RECIPIENT DURING THE SAME HOSPITALIZATION. THESE PAYMENTS HAVE BEEN MADE. THIS CLAIM EXCEEDS THAT MAXIMUM.
5130	YOU HAVE EXCEEDED THE MAXIMUM ALLOWABLE FEE (FIVE HUNDED DOLLARS) FOR PROFESSIONAL / OUTPATIENT SERVICES FOR THIS RECIPIENT ON THE SAME DATE OF SERVICE.
5131	TWO OR MORE ANESTHESIA PROCEDURES PER HOSPITAL
5132	TWO ASSISTANT SURGICAL PROCEDURES WITH SAME DATE OF SERVICE.
5133	LONG TERM CARE LEAVE DAYS EXCEED MAXIMUM ALLOWED (INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED - ICF/MR)
5134	DENTAL APPROVED AMOUNT EXCEEDS THE MAXIMUM ALLOWED
5135	THIS PROFESSIONAL CLAIM REQUIRES MANUAL REVIEW TO VERIFY THE AMOUNT APPROVED LESS CO-PAY DETERMINED BY THE DEPARTMENT. AMOUNT EXCEEDS THE MAXIMUM ALLOWED
5136	THIS PHARMACY CLAIM REQUIRES MANUAL REVIEW TO VERIFY THE AMOUNT APPROVED LESS CO-PAY DETERMINED BY THE DEPARTMENT. AMOUNT EXCEEDS THE MAXIMUM ALLOWED
5137	THIS LONG TERM CARE CLAIM REQUIRES MANUAL REVIEW TO VERIFY THE AMOUNT APPROVED LESS CO-PAY DETERMINED BY THE DEPARTMENT. AMOUNT EXCEEDS THE MAXIMUM ALLOWED
5138	THIS INPATIENT CLAIM REQUIRES MANUAL REVIEW TO VERIFY THE AMOUNT APPROVED LESS CO-PAY DETERMINED BY THE DEPARTMENT. AMOUNT EXCEEDS THE MAXIMUM ALLOWED
5139	LIFETIME LIMIT EXCEEDED (TEN THOUSAND DOLLARS) FOR ENVIRONMENTAL ADAPTATIONS OR SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES/ASSISTIVE TECHNOLOGY. DURABLE MEDICAL EQUIPMENT (DME)
5140	LIFETIME LIMIT EXCEEDED (TWENTY THOUSAND) FOR ENVIRONMENTAL ADAPTATIONS OR SPECIALIZED MEDICAL EQUIPMENT/SUPPLIES/ASSISTIVE TECHNOLOGY.
5141	DUPLICATE BILLING OF RADIOLOGICAL SERVICES
5142	LOCK IN MANAGEMENT FEE LIMITED TO ONE PER MONTH
5143	PAYMENT EXCEEDS MAX ALLOWED PER TOOTH FOR DATES PRIOR TO 1999
5144	MAXIMUM DAILY DOSAGE EXCEEDED FOR COX II
5145	MAXIMUM DAILY DOSAGE EXCEEDED FOR VIOXX
5146	ERECTILE DYSFUNCTION (ED) DRUGS LIMITED TO FOUR PER MONTH
5147	ERECTILE DYSFUNCTION (ED) DRUGS LIMITED TO SIX PER MONTH
5148	RETROACTIVE TOOTH EXTRACTION
5149	$10,000 LIMIT PER LIFETIME ON ASSISTIVE TECHNICAL SERVICE
5150	DAILY PAID AMOUNT EXCEEDS MAX
5151	MATERNITY CARE PAYMENTS LIMITED TO ONE PER 180 DAYS
5153	TOPICAL FLUORIDE LIMITED TO ONE PER DAY.
5154	DISCHARGE DATE IS LESS THAN 61 DAYS PRIOR TO ADMITION DATE
5155	ADMITION DATE IS LESS THAN 61 DAYS AFTER TO DISCHARGE DATE
5156	POSTOPERATIVE VISIT BILLED DURING POSTOPERATIVE TIME (TEN DAYS)
5157	POSTOPERATIVE VISIT BILLED DURING POSTOPERATIVE TIME(45 DAYS)
5158	POSTOPERATIVE VISIT BILLED DURING POSTOPERATIVE TIME (60 DAYS)

5159	POSTOPERATIVE VISIT BILLED DURING POSTOPERATIVE TIME (90 DAYS)
5160	SUSPENDED BY THE OFFICE OF LONG TERM LIVING (OLTL) FOR MANUAL REVIEW
5200	PROCEDURES LIMITED TO ONE PER 30 DAYS
5201	PROCEDURES LIMITED TO ONE PER TWO CALENDAR MONTHS
5202	PROCEDURES LIMITED TO ONE PER 90 DAYS
5203	PROCEDURES LIMITED TO ONE PER 180 DAYS
5204	PROCEDURES LIMITED TO ONE PER 300 DAYS
5205	PROCEDURES LIMITED TO ONE PER CALENDAR YEAR
5206	PROCEDURES LIMITED TO ONE PER TWO CALENDAR YEARS (730 DAYS)
5207	PROCEDURES LIMITED TO ONE PER THREE CALENDAR YEARS
5208	PROCEDURES LIMITED TO ONE PER FIVE CALENDAR YEARS
5209	PROCEDURES LIMITED TO ONE PER LIFETIME
5210	PROCEDURES LIMITED TO TWO PER SEVEN DAYS
5211	PROCEDURES LIMITED TO TWO PER CALENDAR MONTH
5212	PROCEDURES LIMITED TO TWO PER SIX MONTHS
5213	PROCEDURES LIMITED TO TWO PER YEAR (365 DAYS)
5214	PROCEDURES LIMITED TO TWO PER TWO CALENDAR YEARS
5215	PROCEDURES LIMITED TO TWO PER THREE CALENDAR YEARS (1,095 DAYS)
5216	PROCEDURES LIMITED TO TWO PER SIX YEARS
5217	PROCEDURES LIMITED TO TWO PER LIFETIME
5218	PROCEDURES LIMITED TO THREE PER SEVEN DAYS
5219	PROCEDURES LIMITED TO THREE PER MONTH
5220	PROCEDURES LIMITED TO THREE PER YEAR
5221	PROCEDURES LIMITED TO FOUR PER SEVEN DAYS
5222	PROCEDURES LIMITED TO FOUR PER CALENDAR MONTH
5223	PROCEDURES LIMITED TO FOUR PER 365 DAYS
5224	PROCEDURES LIMITED TO FOUR PER CALENDAR YEAR
5225	PROCEDURES LIMITED TO FOUR PER TWO YEARS
5226	PROCEDURES LIMITED TO FOUR PER THREE YEARS
5227	PROCEDURES LIMITED TO FOUR PER LIFETIME
5228	PROCEDURES LIMITED TO FIVE PER MONTH
5229	PROCEDURES LIMITED TO FIVE PER 60 DAYS
5230	PROCEDURES LIMITED TO FIVE PER YEAR
5231	PROCEDURES LIMITED TO SIX PER 30 DAYS
5232	PROCEDURES LIMITED TO SIX PER YEAR
5233	PROCEDURES LIMITED TO SIX PER THREE YEARS
5234	PROCEDURES LIMITED TO SEVEN PER SEVEN DAYS

5235	PROCEDURES LIMITED TO SEVEN PER MONTH
5236	PROCEDURES LIMITED TO EIGHT PER MONTH
5237	PROCEDURES LIMITED TO EIGHT PER YEAR
5238	PROCEDURES LIMITED TO EIGHT PER THREE YEARS
5239	PROCEDURES LIMITED TO EIGHT PER LIFETIME
5240	PROCEDURES LIMITED TO NINE PER DAY
5241	PROCEDURES LIMITED TO TEN PER SEVEN DAYS
5242	PROCEDURES LIMITED TO TEN PER MONTH
5243	PROCEDURES LIMITED TO TEN PER SIX MONTHS
5244	PROCEDURES LIMITED TO TEN PER YEAR
5245	PROCEDURES LIMITED TO TEN PER LIFETIME
5246	PROCEDURES LIMITED TO 12 PER CALENDAR MONTH
5247	PROCEDURES LIMITED TO 12 PER YEAR
5248	PROCEDURES LIMITED TO 12 PER LIFETIME
5249	PROCEDURES LIMITED TO 14 PER MONTH
5250	PROCEDURES LIMITED TO 15 PER CALENDAR MONTH
5251	PROCEDURES LIMITED TO 15 PER 185 DAYS
5252	PROCEDURES LIMITED TO 15 PER YEAR
5253	PROCEDURES LIMITED TO 16 PER MONTH
5254	PROCEDURES LIMITED TO 18 PER MONTH
5255	PROCEDURES LIMITED TO 18 PER 90 DAYS
5256	PROCEDURES LIMITED TO 20 PER SIX MONTHS
5257	PROCEDURES LIMITED TO 20 PER YEAR
5258	PROCEDURES LIMITED TO 20 PER LIFETIME
5259	PROCEDURES LIMITED TO 21 PER MONTH
5260	PROCEDURES LIMITED TO 24 PER MONTH
5261	PROCEDURES LIMITED TO 24 PER LIFETIME
5262	PROCEDURES LIMITED TO 30 PER CALENDAR MONTH
5263	PROCEDURES LIMITED TO 31 PER MONTH
5264	PROCEDURES LIMITED TO 34 PER 90 DAYS
5265	PROCEDURES LIMITED TO 35 PER CALENDAR MONTH
5266	PROCEDURES LIMITED TO 36 PER MONTH
5267	PROCEDURES LIMITED TO 36 PER YEAR
5268	PROCEDURES LIMITED TO 40 PER SEVEN DAYS
5269	PROCEDURES LIMITED TO 40 PER CALENDAR MONTH
5270	PROCEDURES LIMITED TO 40 PER 90 DAYS
5271	PROCEDURES LIMITED TO 42 PER YEAR

5272	PROCEDURES LIMITED TO 45 PER CALENDAR MONTH
5273	PROCEDURES LIMITED TO 48 PER SEVEN DAYS
5274	PROCEDURES LIMITED TO 48 PER MONTH
5275	PROCEDURES LIMITED TO 50 PER MONTH
5276	PROCEDURES LIMITED TO 50 PER YEAR
5277	PROCEDURES LIMITED TO 60 PER MONTH
5278	PROCEDURES LIMITED TO 67 PER 90 DAYS
5279	PROCEDURES LIMITED TO 72 PER 30 DAYS
5280	PROCEDURES LIMITED TO 79 PER 90 DAYS
5281	PROCEDURES LIMITED TO 80 PER MONTH
5282	PROCEDURES LIMITED TO 80 PER 60 DAYS
5283	PROCEDURES LIMITED TO 84 PER LIFETIME
5284	PROCEDURES LIMITED TO 90 PER CALENDAR MONTH
5285	PROCEDURES LIMITED TO 93 PER MONTH
5286	PROCEDURES LIMITED TO 96 PER MONTH
5287	PROCEDURES LIMITED TO 100 PER SEVEN DAYS
5288	PROCEDURES LIMITED TO 100 PER 30 DAYS
5289	PROCEDURES LIMITED TO 104 PER YEAR
5290	PROCEDURES LIMITED TO 120 PER MONTH
5291	PROCEDURES LIMITED TO 140 PER SEVEN DAYS
5292	PROCEDURES LIMITED TO 144 PER 30 DAYS
5293	PROCEDURES LIMITED TO 150 PER MONTH
5294	PROCEDURES LIMITED TO 160 PER MONTH
5295	PROCEDURES LIMITED TO 180 PER MONTH
5296	PROCEDURES LIMITED TO 200 PER MONTH
5297	PROCEDURES LIMITED TO 240 PER SEVEN DAYS
5298	PROCEDURES LIMITED TO 240 PER 14 DAYS
5299	PROCEDURES LIMITED TO 248 PER MONTH
5300	PROCEDURES LIMITED TO 256 PER SEVEN DAYS
5301	PROCEDURES LIMITED TO 278 PER MONTH
5302	PROCEDURES LIMITED TO 300 PER 30 DAYS
5303	PROCEDURES LIMITED TO 312 PER YEAR
5304	PROCEDURES LIMITED TO 336 PER 14 DAYS
5305	PROCEDURES LIMITED TO 360 PER MONTH
5306	PROCEDURES LIMITED TO 400 PER MONTH
5307	PROCEDURES LIMITED TO 540 PER MONTH
5308	PROCEDURES LIMITED TO 600 PER MONTH

5309	PROCEDURES LIMITED TO 656 PER MONTH
5310	PROCEDURES LIMITED TO 664 PER MONTH
5311	PROCEDURES LIMITED TO 666 PER MONTH
5312	PROCEDURES LIMITED TO 720 PER MONTH
5313	PROCEDURES LIMITED TO 720 PER YEAR
5314	PROCEDURES LIMITED TO 744 PER MONTH
5315	PROCEDURES LIMITED TO 960 PER MONTH
5316	PROCEDURES LIMITED TO 1,200 PER 30 DAYS
5317	PROCEDURES LIMITED TO 1,280 PER MONTH
5318	PROCEDURES LIMITED TO 1,440 PER MONTH
5319	PROCEDURES LIMITED TO 1,440 PER YEAR
5320	PROCEDURES LIMITED TO 1,488 PER MONTH
5321	PROCEDURES LIMITED TO 1,500 PER 30 DAYS
5322	PROCEDURES LIMITED TO 1,600 PER MONTH
5323	PROCEDURES LIMITED TO 2,880 PER YEAR
5324	PROCEDURES LIMITED TO 2,976 PER MONTH
5325	PROCEDURES LIMITED TO 3,000 PER CALENDAR MONTH
5326	COMPLETE/PARTIAL DENTURE LIMIT TO ONE PER ARCH PER FIVE YEARS
5327	PROCEDURES LIMITED TO ONE IN LIFETIME PER ARCH
5328	PROCEDURES LIMITED TO ONE PER FIVE YEARS PER PROVIDER
5329	PROCEDURES LIMITED TO ONE PER LIFETIME PER PROVIDER
5330	PROCEDURES LIMITED TO ONE PER TOOTH PER THREE YEARS
5331	SEALANTS LIMITED TO ONE PER TOOTH PER LIFETIME
5332	PROCEDURES LIMITED TO ONE PER 180 DAYS PER PROVIDER
5333	RENAL DIALYSIS PROCEDURES LIMITED TO 15 PER CALENDAR YEAR
5334	PROCEDURE LIMITED TO ONE PER 365 DAYS PER PROVIDER
5335	PROCEDURES LIMITED TO THREE PER YEAR
5336	PROCEDURE LIMITED TO FOUR PER TWO YEARS PER ARCH
5337	PROCEDURE LIMITED TO FOUR PER LIFETIME PER QUADRANT
5338	PROCEDURE LIMITED TO TWO PER LIFETIME - ONE PER ARCH
5339	DURABLE MEDICAL EQUIPMENT (DME) PURCHASE LIMITED TO ONE PER 1,825 DAYS (FIVE YEARS)
5340	DURABLE MEDICAL EQUIPMENT (DME) PURCHASE LIMITED TO ONE PER 1,095 DAYS (THREE YEARS)
5341	DURABLE MEDICAL EQUIPMENT (DME) CANNOT BE UNBUNDLED
5342	WALKER ACCESSORIES LIMITED TO ONE PER 365 DAYS
5343	WHEELCHAIR ACCESSORIES LIMITED TO ONE PER 365 DAYS
5344	PROCEDURE CODE REQUIRES MEDICAL REVIEW
5345	DURABLE MEDICAL EQUIPMENT (DME) LIMITED TO ONE PER TWO YEARS

5346	PROCEDURES LIMITED TO ONE PER LIFETIME
5347	FAMILY PLANNING (FP) PROCEDURES LIMITED TO ONE PER YEAR WITH THE SAME PROVIDER
5348	FAMILY PLANNING (FP) PROCEDURES LIMITED TO FOUR PER YEAR
5349	FAMILY PLANNING (FP) - PROCEDURES CANNOT BE BILLED CONCURRENTLY WITHIN 90 DAYS
5350	DRUG LIMITED TO FOUR PER 28 DAYS
5351	DRUG LIMITED TO EIGHT PER 28 DAYS
5352	DRUG LIMITED TO 300 PER 28 DAYS
5353	DRUG LIMITED TO ONE PER 30 DAYS
5354	DRUG LIMITED TO TWO PER 30 DAYS
5355	DRUG LIMITED TO THREE PER 30 DAYS
5356	DRUG LIMITED TO FOUR PER 30 DAYS
5357	DRUG LIMITED TO SIX PER 30 DAYS
5358	DRUG LIMITED TO NINE PER 30 DAYS
5359	DRUG LIMITED TO TEN PER 30 DAYS
5360	DRUG LIMITED TO 12 PER 30 DAYS
5361	DRUG LIMITED TO 18 PER 30 DAYS
5362	DRUG LIMITED TO 20 PER 30 DAYS
5363	DRUG LIMITED TO 30 PER 30 DAYS
5364	DRUG LIMITED TO 60 PER 30 DAYS
5365	DRUG LIMITED TO 90 PER 30 DAYS
5366	DRUG LIMITED TO 120 PER 30 DAYS
5367	DRUG LIMITED TO 150 PER 30 DAYS
5368	DRUG LIMITED TO 180 PER 30 DAYS
5369	DRUG LIMITED TO 270 PER 30 DAYS
5370	DRUG LIMITED TO 600 PER 30 DAYS
5371	DRUG LIMITED TO 750 PER 30 DAYS
5372	DRUG LIMITED TO 900 PER 30 DAYS
5373	DRUG LIMITED TO FIVE PER 30 DAYS
5374	DRUG LIMITED TO 2,160 PER 30 DAYS
5375	RECIPIENT ELIGIBLE FOR DENTAL SERVICES IN PLACE OF SERVICE (POS) 21 & 24 ONLY
5376	HEALTH CARE BENEFIT PACKAGE (HCBP) NOT ELIGIBLE FOR INPATIENT / LONG TERM CARE (LTC) SERVICES
5377	HEALTH CARE BENEFIT PACKAGE (HCBP) NOT ELIGIBLE FOR AMBULATORY SURGICAL CENTER (ASC) / SPECIAL PROCEDURE UNIT (SPU) SERVICE
5380	PROCEDURES LIMITED TO 300 PER MONTH
5381	BILATERAL PROCEDURES LIMITED TO ONE PER 90 DAYS
5382	PROCEDURES LIMITED TO FOUR PER MONTH
5383	PROCEDURES LIMITED TO 60 PER MONTH

5384	PROCEDURES LIMITED TO TWO PER 1,095 DATS
5385	PROCEDURE CODE ENTERAL FORMULA LIMITED TO 960 PER MONTH
5386	PROCEDURES CANNOT BE BILLED WITHIN 365 DAYS
5387	PROCEDURES CANNOT BE BILLED MORE THAN ONE IN 1,095 DAYS
5388	PROCEDURES LIMITED TO TWO PER THREE YEARS
5389	PROCEDURES LIMIT TO ONE PER YEAR
5390	PROCEDURES LIMITED TO EIGHT PER THREE YEARS (FOUR PER SIDE)
5391	SPINE / BACK ORTHOSES LIMIT TO ONE PER 365 DAYS
5392	LIMIT PROCEDURE TO ONE PER DAY
5393	PROCEDURES LIMIT TO TWO PER THREE YEARS (ONE PER SIDE)
5394	PROCEDURES LIMIT TO EIGHT PER THREE YEARS (FOUR PER SIDE)
5395	PROCEDURES LIMIT TO 300 PER THREE MONTHS
5396	LIMIT 99501/AT TO TWO PER 365 DAYS
5397	PROCEDURE NOT TO BE BILLED MORE THAN TWO IN 180 DAYS
5398	THREE UNITS PER 60 DAYS
5399	COMPLETE MEDICAL OR PSYCHOLOGICAL EVALUATION LIMITED TO ONE PER 365 DAYS
5400	PRIOR AUTHORIZATION (PA) REQUIRED FOR NON-SEDATING ANTIHISTAMINES DRUGS
5401	NON-SEDATING ANTIHISTAMINES (NSA) DRUGS LIMITED TO 30 PER MONTH
5402	NON-SEDATING ANTIHISTAMINES (NSA) DRUGS LIMITED TO 60 PER MONTH
5403	NON-SEDATING ANTIHISTAMINES (NSA) DRUGS LIMITED TO 300 PER MONTH
5404	PSYCHIATRIC EVALUATIONS LIMITED TO TWO PER YEAR
5405	MEDICAL MANAGEMENT VISIT LIMIT TO FOUR UNITS PER CALENDAR MONTH
5406	MEDICAL MANAGEMENT VISIT LIMIT TO FOUR UNITS PER CALENDAR MONTH
5407	SUMMER THERAPEUTIC ACTIVITIES PROGRAM (STAP) LIMITED TO 150 HOURS PER YEAR
5408	MEDICAL VISIT/CLOZAPINE VISIT LIMIT FIVE PER CALENDAR MONTH
5409	PSYCHIATRIC CLINIC MEDICAL VISIT LIMIT THREE PER 30 DAYS
5410	DRUG AND ALCOHOL (D&A) CLINIC VISIT LIMITED TO ONE PER DAY.
5411	ASSESSMENT AND ASSISTANCE LIMIT 36 HOURS PER MONTH
5412	COMPREHENSIVE METHADONE MAIN LIMIT ONE PER WEEK
5413	MUSIC THERAPY LIMITED TO ONE HOUR PER DAY
5414	TAKE HOME METHADONE LIMITED TO 14 UNITS PER 16 DAYS
5415	SERVICES BY PSYCHIATRIC NURSE / SOCIAL WORKER LIMITED TO 12 PER DAY
5416	SERVICES LIMIT TO ONE TO FIVE UNITS PER DAY
5417	VISIT PAYMENT EXCEEDS HEALTHY BEGINNINGS PLUS (HBP) PACKAGE PRICING
5418	VISIT PAYMENT EXCEEDS HEALTHY BEGINNINGS PLUS (HBP) PACKAGE PRICING
5419	VISIT PAYMENT EXCEEDS HEALTHY BEGINNINGS PLUS (HBP) PACKAGE PRICING
5420	VISIT PAYMENT EXCEEDS HEALTHY BEGINNINGS PLUS (HBP) PACKAGE PRICING

5421	DRUG-FREE CLINIC VISIT LIMITED TO THREE PER 30 DAYS
5422	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 332 PER MONTH.
5423	SCHOOL BASED ACCESS PROCEDURE LIMITED TO $15,000.00.
5424	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 664 PER MONTH.
5425	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 240 PER SEVEN DAYS.
5426	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 140 PER SEVEN DAYS.
5427	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 30 PER MONTH.
5428	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 48 PER SEVEN DAYS.
5429	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 1,600 PER MONTH.
5430	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 656 PER MONTH.
5431	SCHOOL BASED ACCESS PROCEDURE LIMITED TO ONE PER LIFETIME.
5432	SCHOOL BASED ACCESS PROCEDURE LIMITED TO THREE PER 365 DAYS.
5433	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 1,280 PER MONTH.
5434	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 31 PER MONTH.
5435	VISIT PAYMENT EXCEEDS HEALTHY BEGINNINGS PLUS (HBP) PACKAGE PRICING
5436	VISIT PAYMENT EXCEEDS HEALTHY BEGINNINGS PLUS (HBP) PACKAGE PRICING
5437	VISIT PAYMENT EXCEEDS HEALTHY BEGINNINGS PLUS (HBP) PACKAGE PRICING
5438	SLEEP STUDIES LIMITED TO TWO PER 365 DAYS
5439	PROCEDURE CODES LIMITED TO ONE PER 180 DAYS (PT47)
5440	VISIT LIMITS FOR FIRST TRIMESTER - BIRTHING CENTER
5441	VISIT LIMITS FOR SECOND TRIMESTER - BIRTHING CENTER
5442	VISIT LIMIT FOR THIRD TRIMESTER - BIRTHING CENTER
5443	PAYMENT LIMITED TO TRIMESTER PACKAGE OR VISITS
5444	PAYMENT FOR TRIMESTER PACKAGE LIMIT - ONE PER 90 DAYS
5445	ONLY SPECIALTY PHARMACIES MAY BILL FOR 'S' CODES
5446	LIMIT 200 UNITS PER PERSON PER FISCAL YEAR
5447	LIMIT 300 UNITS PER PERSON PER FISCAL YEAR
5448	TOTAL PAYMENT EXCEEDS PROVIDER LIMIT
5449	DUPLICATE DENTAL ANESTHESIA CODES BILLED
5451	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 23 PER MONTH
5452	SCHOOL BASED ACCESS PROCEDURE LIMITED TO 60 PER MONTH
5453	MEDICAL ASSISTANCE (MA) FEE CUTBACK DUE TO RELATED PROCEDURES
5454	AFTER CUTBACK - CLAIM PRICED AT ZERO
5455	FAMILY PLANNING TITLE V AND XX / ONE PER 365 DAYS
5456	TITLE X & TITLE XX LIMIT SEVEN PER 180 DAYS
5457	TITLE V & TITLE XX LIMIT 365 PER 365 DAYS
5458	TITLE V & TITLE XX LIMIT ONE PER 1,095 DAYS (THREE YEARS)

5459	PAYMENT OF 90649 WITH MODIFIER 'U5' FOR TITLE V AND XX ONLY
5460	PROCEDURES LIMITED TO ONE PER 730 DAYS
5461	ONE TECHNICAL COMPONET AND ONE PROFESSIONAL COMPONENT WITHIN 730 DAYS
5462	AMBULATORY SURGICAL CENTER (ASC) /SPECIAL PROCEDURE UNIT (SPU) LIMIT - ONE PROCEDURE PER DAY WITH 'SG' MODIFIER
5463	BL LIMIT - ONE PER CALENDAR MONTH PER EXTREMITY - RR
5464	ONE PER EXTREMITY PER 1,095 DAYS (THREE YEARS) BL
5465	W/C ARM REST PAIRS - ONE PER CALENDAR MONTH - RR
5466	SCHOOL BASED ACCESS PROCEDURE LIMITED TO ONE PER 30 DAYS
5467	SCHOOL BASED ACCESS PROCEDURES LIMITED TO ONE PER 180 DAYS
5475	PRIOR AUTHORIZATION (PA) REQUIRED, DRUG IS NON-PREFERRED
5476	EMERGENCY SUPPLY BYPASS OF PREFERRED DRUG LIST (PDL) DRUG
5477	THIRD PARTY LIABILITY (TPL) BYPASS OF PREFERRED DRUG LIST (PDL) DRUG
5478	PRIOR AUTHORIZATION (PA) REQUIRED FOR CHRONIC THERAPY OF PROTON PUMP INHIBITOR (PPI)
5479	TWO OR MORE SHORT ACTING ANALGESICS REQUIRED PRIOR AUTHORIZATION (PA)
5480	TWO OR MORE LONG ACTING ANALGESICS REQUIRED PRIOR AUTHORIZATION (PA)
5481	PRIOR AUTHORIZATION (PA) REQUIRED FOR THIS ANTICONVULSANT DRUG
5482	PRIOR AUTHORIZATION (PA) REQUIRED FOR SPIRIVA IF RECIPIENT AGE LESS THAN 45
5483	PRIOR AUTHORIZATION (PA) REQUIRED FOR THIS HYPOGLYCEMIC DRUG
5484	PRIOR AUTHORIZATION (PA) REQUIRED FOR BRAND NAME COMTAN
5485	CLINICAL PRIOR AUTHORIZATION (PA) REQUIRED FOR THIS DRUG
5486	PROCEDURE GROUP LIMITED TO 36 PER 365 DAYS.
5487	PROCEDURE GROUP LIMITED TO 96 PER 30 DAYS
5488	CLINICAL PRIOR AUTHORIZATION (PA) REQUIRED BYPASSED DUE TO THIRD PARTY LIABILITY (TPL)
5489	EMERGENCY SUPPLY BYPASS OF CLINICAL PRIOR AUTHORIZATION (PA)
5490	EARLY INTERVENTION 36 PER 365 DAYS
5491	EARLY INTERVENTION - LIMIT 36 PER 365 DAYS - EXACT MATCH
5492	EARLY INTERVENTION - LIMIT 60 PER 30 DAYS.
5493	NURSE-FAMILY PARTNERSHIP (NFP) ASSESSMENT/EVALUATION LIMITED TO ONE PER LIFETIME
5495	HEALTHY BEGINNINGS PLUS (HBP) OR NURSE-FAMILY PARTNERSHIP (NFP) SERVICES - NOT BOTH WITHIN TEN MONTHS
5496	HEALTHY BEGINNINGS PLUS (HBP) THIRD TRIMESTER BILLED AFTER NURSE-FAMILY PARTNERSHIP (NFP) SERVICES
5497	OUTPATIENT PSYCH AND PARTIAL HOSPITALIZATION NOT PAYABLE ON SAME DATE OF SERVICE
5498	PEER SPECIALIST LIMIT TO EIGHT UNITS PER DAY IN PLACE OF SERVICE (POS) 21/31/32
5499	PEER SPECIALIST LIMITED TO 16 UNITS PER DAY.
5500	YOU HAVE BILLED THE DEPARTMENT FOR A VISIT WITHIN A POSTOPERATIVE PERIOD OF A SURGICAL, OBSTETRICAL OR ANESTHESIA PROCEDURE. THE REGULATIONS STATE THE FEE FOR THIS VISIT IS INCLUDED IN THE PAYMENT FOR THE PROCEDURE
5501	THE DEPARTMENT'S RECORDS INDICATE YOU HAVE ALREADY BEEN PAID FOR A VISIT THAT IS IN THE POSTOPERATIVE LIMIT OF THE PROCEDURE YOU ARE BILLING. PLEASE SUBMIT A CLAIM ADJUSTMENT TO RETURN THE PAYMENT FOR THE VISIT BEFORE YOU RESUBMIT THIS SURGICAL, OBSTETRIC OR ANESTHESIA PROCEDURE.

5502	AN INPATIENT HOSPITAL VISIT WAS BILLED AND A SURGICAL PROCEDURE WAS PERFORMED DURING THE HOSPITALIZATION PERIOD. THE DEPARTMENT'S FEE FOR THE SURGICAL PROCEDURE INCLUDES INPATIENT HOSPITAL VISITS.
5503	PAYMENT FOR INPATIENT CONSULTATION INCLUDES FOLLOW-UP CARE; THEREFORE THE CONSULTANT IS NOT ELIGIBLE TO BILL FOR DAILY MEDICAL CARE. ONLY THE ATTENDING PHYSICIAN IS ENTITLED TO BILL FOR DAILY MEDICAL CARE.
5504	RELATED PROCEDURES HAVE BEEN BILLED ON THE SAME DATE OF SERVICE.
5505	YOUR CLAIM HAS SUSPENDED TO VERIFY THE DEPARTMENT'S RECORDS.
5506	CONSULTATION, SURGERY OR ORAL SURGERY LIMIT
5507	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (3 DAYS)
5508	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (5 DAYS)
5509	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (7 DAYS)
5510	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (10 DAYS)
5511	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (14 DAYS)
5512	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (15 DAYS)
5513	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (21 DAYS)
5514	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (30 DAYS)
5515	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (45 DAYS)
5516	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (60 DAYS)
5517	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (75 DAYS)
5518	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (90 DAYS)
5519	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (100 DAYS)
5520	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (120 DAYS)
5521	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (150 DAYS)
5522	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (176 DAYS)
5523	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (180 DAYS)
5524	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (270 DAYS)
5525	POST OPERATIVE VISIT BILLED DURING POST OPERATIVE TIME (365 DAYS)
5526	ASSESSMENT CODE REQUIRED FOR S0302 (EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT - EPSDT SCREEN)
5527	CONSULTATION OR SURGERY IS PAYABLE, BUT NOT BOTH
5528	RELATED PROCEDURES CANNOT BE BILLED ON SAME DATE OF SERVICE (DOS)
5529	RELATED PROCEDURES MUST BE BILLED TOGETHER
5530	RELATED PROCEDURES REQUIRE MEDICAL REVIEW
5531	SERVICES NON-COMPENSABLE FOR RECIPIENT SAME DATE OF SERVICE (DOS)
5532	RELATED PROCEDURE MUST BE PAID IN HISTORY ON SAME DATE OF SERVICE (DOS)
5533	RELATED PROCEDURES REQUIRE MEDICAL REVIEW - DP
5534	A0429 MUST BE PAID IN HISTORY FOR PAYMENT OF A0432
5535	PRIMARY CODE MUST BE BILLED BEFORE ADD ON CODE
5536	PRIMARY CODE MUST BE BILLED BEFORE ADD ON (DIFFERENT)
5539	LIMITED TO 1,440 UNITS PER FISCAL YEAR

5540	OUTREACH BONUS CRITERIA NOT MET
5541	COMBINATION OF PROCEDURES LIMITED TO ONE PER DAY
5543	PEER SPECIALIST LIMITED TO 900 HOURS PER CALENDAR YEAR
5544	PEER SPECIALIST LIMITED TO ONE PROVIDER PER DAY - INPATIENT
5545	REVIEW FOR MANAGED CARE ORGANIZATION (MCO) ELIGIBILITY - OUTPATIENT HOSPITAL
5546	MOBILE MENTAL HEALTH TREATMENT (MMHT) SERVICES OR OUT PATIENT PSYCHOLOGICAL CLINIC ON SAME DATE OF SERVICE (DOS)
5547	MOBILE MENTAL HEALTH TREATMENT (MMHT) SERVICES AND PARTIAL SERVICES CAN NOT BE BILLED ON THE SAME DAY
5548	SERVICE MUST BE BILLED TO BEHAVIORAL HEALTH (BH) MANAGED CARE PLAN
5549	RURAL HEALTH CLINIC (RHC) / FEDERALLY QUALIFIED HEALTH CENTER (FQHC) - REVIEW FOR MANAGED CARE ELIGIBILITY
5550	REVIEW PHYSICAL HEALTH (PH) MANAGED CARE ORGANIZATION (MCO) ELIGIBILITY FOR 96110 & 96110/U1
5551	$10,000 LIFETIME LIMITATION FOR AUTISM
5552	COMMUNITY INCLUSION 50 HOUR LIMITATION.
5553	$4,000 LIFETIME LIMITATION FOR AUTISM
5554	$20,000 LIFETIME LIMITATION FOR AUTISM
5555	$6,240 PER ROLLING 365 DAY LIMITATION FOR AUTISM
5556	GREATER THAN 40 UNITS ON SAME DAY FOR AUTISM
5557	GREATER THAN 40 UNITS ON TWO CONSECUTIVE DAYS
5558	SAME DAY SERVICES FOR AUTISM
5559	TRANSITIONAL WORK SERVICES MAX 48 UNITS - AUTISM
5560	DELIVERIES LIMITED TO ONE PER SIX MONTHS
5561	ONE MONTHLY ADMINISTRATIVE FEE ALLOWED PER MONTH PER CONSUMER
5562	BILL MONTHLY ADMINISTRATIVE FEE IN THE FOLLOWING MONTH
5563	BILL ADMINISTRATIVE FEE FOR CAMP OR TRANSPORTATION/WEEK/CONSUMER
5564	SERVICE PROGRAM CONFLICT - BILL BASE SERVICES SEPARATELY
5565	SERVICE PROGRAM CONFLICT - VOID ORIGINAL CLAIM & RE-BILL
5566	DATES OF SERVICE MISMATCH FOR SERVICE & ADMINISTRATIVE FEE
5567	ONE TIME ADMINISTRATIVE FEE & SERVICE MUST BE BILLED ON SAME CLAIM
5568	SERVICE PROGRAM CHANGE FOR ADMINISTRATIVE FEE
5569	ADMINISTRATIVE FEE ON CLAIM SUSPENDS WHEN SERVICE IS SUSPENDED
5570	ADMINISTRATIVE FEE ON CLAIM DENIED WHEN SERVICE DENIED
5571	NO PROVIDER SPECIFIC RATE FOR MONTHLY ADMINISTRATIVE FEE
5572	THE PROCEDURE CODE FOR THE MONTHLY ADMINISTRATIVE FEE CANNOT SPAN A CALENDAR MONTH
5573	MORE THAN ONE MONTHLY ADMINISTRATIVE FEE BILLED PER INDIVIDUAL PER MONTH
5574	MULTIPLE TYPES OF ADMINISTRATIVE FEES BILLED IN SAME MONTH
5575	COUNTY CODE MISSING OR INVALID ON CLAIM
5576	RESPITE DAYS GREATER THAN 30 DAYS IN A STATE FISCAL YEAR
5577	MORE THAN 1,040 UNITS BILLED IN STATE FISCAL YEAR

5578	FUNDING CONFLICT - BILL UNITS GREATER THAN 30 ON A SEPARATE CLAIM
5579	PAID SERVICE EXCEEDS 12 CONSECUTIVE MONTHS
5580	RESPITE SERVICES GREATER THAN 28 DAYS IN STATE FISCAL YEAR
5581	LIMITED TO 480 UNITS PER FISCAL YEAR
5582	LIMITED TO $10,000 IN A FIVE YEAR PERIOD
5583	NO ADDITIONAL PAYMENT IS DUE FROM THE OFFICE OF DEVELOPMENTAL PROGRAMS (ODP).
5584	MORE THAN FOUR SESSIONS ARE BILLED IN A CALENDAR MONTH
5586	PAID CLAIMS ARE GREATER THAN $500 IN STATE FISCAL YEAR
5587	HOME & COMMUNITY HABILITATION AND COMPANION SERVICES GREATER THAN 672 UNITS PER WEEK
5588	DAY & EMPLOYMENT SERVICES BILLED GREATER THAN 160 UNITS PER WEEK
5589	INELIGIBLE MEDICAL DAYS CUTBACK 30 IN STATE FISCAL YEAR
5590	THERAPEUTIC DAYS GREATER THAN 48 DAYS IN A STATE FISCAL YEAR
5591	GREATER THAN 40 HOURS IN STATE FISCAL YEAR
5592	'U4' MODIFIER NOT ALLOWED WITH CODE FOR BASE FUNDED SERVICES
5593	EXCEEDED $20,000 IN TEN YEAR PERIOD LIMIT PER CONSUMER
5594	CANNOT HAVE MORE THAN ONE TYPE OF ADMINISTRATIVE FEE BILLED DURING THE SAME CALENDAR MONTH.
5595	INELIGIBLE MEDICAL LEAVE GREATER THAN 30 DAYS IN FISCAL YEAR
5596	INELIGIBLE THERAPEUTIC LEAVE GREATER THAN 48 DAYS IN A STATE FISCAL YEAR
5597	CAMP/TRANSPORTATION ADMINISTRATIVE FEE - FISCAL YEAR SPAN
5598	'ET' MODIFIER AND NON 'ET' MODIFIER BILLED ON SAME DATE OF SERVICE (DOS).
5599	CANNOT BILL MEDICAL AND THERAPEUTIC ON THE SAME DATE OF SERVICE (DOS).
5600	MULTIPLE DIAGNOSTIC COMPONENTS BILLED ON SAME DATE OF SERVICE (DOS)
5601	LONG TERM CARE (LTC) RESIDENT - NO MEDICAL SUPPLIES / DURABLE MEDICAL EQUIPMENT (DME) IN PLACE OF SERVICE (POS) 11 & 12
5602	PROCEDURES LIMITED TO 60 PER 30 DAYS - GRP
5603	PROCEDURES LIMITED TO 144 PER 30 DAYS - GRP
5604	PROCEDURES LIMITED TO TWO PER 365 DAYS - GRP
5605	PROCEDURES LIMITED TO 30 PER 30 DAYS - GRP
5606	PROCEDURES LIMITED TO FOUR PER 30 DAYS - GRP
5607	PROCEDURES LIMITED TO 16 PER 30 DAYS - GRP
5608	PROCEDURES LIMITED TO TWO PER 30 DAYS - GRP
5609	PROCEDURES LIMITED TO SIX PER 30 DAYS - GRP
5610	PROCEDURES LIMITED TO ONE PER 180 DAYS - GRP
5611	PROCEDURES LIMITED TO ONE PER CALENDAR MONTH - GRP
5612	PROCEDURES LIMITED TO EIGHT PER 30 DAYS - GRP
5613	PROCEDURES LIMITED TO 100 PER 30 DAYS - GRP
5614	PROCEDURES LIMITED TO 120 PER 30 DAYS - GRP

5615	PROCEDURES LIMITED TO 300 PER 30 DAYS - GRP
5616	PROCEDURES LIMITED TO 60 PER 30 DAYS - GRP
5617	PROCEDURES LIMITED TO FOUR PER THREE YEARS - GRP
5618	PROCEDURES LIMITED TO ONE PER 365 DAYS
5619	PROCEDURES LIMITED TO TWO PER SIX MONTHS - GRP
5620	PROCEDURES LIMITED TO 150 PER 30 DAYS - GRP
5621	SERVICE/ITEM IS LIMITED TO ONE PER 1,095 DAYS
5622	SERVICE/ITEM LIMITED TO FOUR PER THREE YEARS
5623	PROCEDURES LIMITED TO 150 PER 30 DAYS - GRP
5624	PAYMENT IS LIMITED TO ONE PER ROLLING SEVEN DAYS
5625	PROCEDURES LIMITED TO TWO PER 365 DAYS - GRP
5626	PROCEDURES LIMITED TO 30 PER MONTH - GRP
5627	PROCEDURES LIMITED TO 16 PER 30 DAYS - GRP
5628	PROCEDURES LIMITED TO TWO PER 30 DAYS - GRP
5629	UNDER PADS LIMITED TO 180 PER 90 DAYS
5630	PROCEDURES LIMITED TO TWO PER 180 DAYS
5631	PROCEDURE LIMITED TO ONE PER FIVE YEARS
5632	PROCEDURES LIMITED TO ONE PER THREE YEARS
5633	PROCEDURES LIMITED TO TWO PER THREE YEARS
5634	LIMIT OF TEN UNITS PER 30 DAYS (ROLLING)
5635	MANUAL REVIEW - LONG TERM CARE (LTC) VENT SERVICES
5636	MANUAL REVIEW OF REPAIR AND PARTS FOR DURABLE MEDICAL EQUIPMENT (DME)
5637	SERVICES LIMITED TO TWO PER CALENDAR YEAR
5638	LENSES LIMITED TO TWO PER SIDE PER CALENDAR YEAR
5639	INSERTS AND ARCHES LIMITED TO EIGHT PER THREE YEARS
5640	INSERTS AND ARCHES LIMITED TO TWO PER THREE YEARS
5641	SERVICE LIMITED TO ONE PER 90 DAYS PER RECIPIENT
5642	CLAIMS FOR COST SHARING MUST BE SUBMITTED WITH EXPLANATION OF BENEFITS (EOB)
5643	POST & CORE NOT PAYABLE WITH RESTORATIONS ON SAME DATE OF SERVICE (DOS)
5644	SERVICE LIMITED TO 70 UNITS PER CALENDAR YEAR PER RECIPIENT
5645	SUPPLIES LIMITED TO THREE PER SIX CALENDAR MONTHS
5646	LIMIT OF THREE PER LIFETIME
5647	SERVICES LIMITED TO 50 PER CALENDAR MONTH
5648	FINANCIAL MANAGEMENT SERVICES (FIN MGT SVCS) LIMIT ONE PER LIFETIME PER PARTICIPANT
5649	ONE HEALTH ASSESSMENT PER EAR PER 365 DAYS. PAYMENT FOR BINAURAL / PAYMENT FOR MONAURAL WITHIN 365 DAYS.
5650	PROCEDURES LIMITED TO TWO PER EXTREMITY PER 30 DAYS
5651	ONE PER EXTREMITY PER 1,095 DAYS (THREE 3YEARS) (BILATERAL)

5652	PROCEDURES LIMITED TO TWO PER CALENDAR MONTH - (BILATERAL)
5653	ONE PER EXTREMITY PER 180 DAYS (SIX MONTHS) (BILATERAL)
5654	PROCEDURES LIMITED TO FOUR PER YEAR (BILATERAL)
5655	FOUR PER EXTREMITY PER 365 DAYS (1 YEAR) (BILATERAL)
5656	PROCEDURES LIMITED TO FOUR PER 180 DAYS - (BILATERAL)
5657	ONE LENS PER EYE PER 365 DAYS
5658	FOUR PER EXTREMITY PER 1,095 DAYS (THREE YEARS) (BILATERAL)
5659	PROCEDURES LIMITED TO TWO PER 1,095 DAYS (THREE YEARS) (BILATERAL)
5660	PROCEDURES LIMITED TO TWO PER LIFETIME - (BILATERAL)
5661	PROCEDURES LIMITED TO TWO PER 365 DAYS - (BILATERAL)
5662	E0935 IS LIMITED TO 21 TIMES PER KNEE PER LIFETIME
5663	TARGETED OUT PATIENT SERVICES LIMIT TO TWO PER 365 DAYS.
5664	TARGETED OUT PATIENT SERVICES LIMITED TO 1,260 MINUTES PER 30 DAYS
5665	TARGETED OUT PATIENT SERVICES LIMIT THREE PER CALENDAR YEAR.
5666	TARGETED OUT PATIENT SERVICES LIMIT 120 MINUTES PER 30 DAYS.
5667	TARGET OUT PATIENT SERVICES MANUAL REVIEW REQUIRED OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES (OMHSAS).
5668	CLAIM EXCEEDS 1,260 MINUTES FOR 30 DAY TARGETED OUT PATIENT SERVICES
5669	ONLY ONE SERVICE AND ONE TIME ADMINISTRATIVE FEE ON A CLAIM
5670	LIMITED TO $10,000 PER CLAIM DETAIL (SERVICE LINE)
5671	GREATER THAN 30 DAYS OF MEDICAL AND/OR THERAPEUTIC LEAVE DAYS IN STATE FISCAL YEAR
5672	PROCEDURES LIMITED TO 60 PER ROLLING 30 DAYS
5673	PROCEDURES LIMITED TO 30 PER 30 DAYS
5674	PROCEDURES LIMITED TO 4,800 PER 30 DAYS
5675	PROCEDURES LIMITED TO FIVE PER 90 DAYS (LABS)
5676	PROCEDURES LIMITED TO ONE PER 90 DAYS G-TUBE (GASTROSTOMY-TUBE)
5677	PROCEDURES LIMITED TO 180 PER 90 DAYS
5678	PROCEDURES LIMITED TO 360 PER 60 DAYS
5679	PROCEDURES LIMITED TO ONE PER 90 DAYS (BILATERAL)
5680	FINGER PROCEDURE / MODIFIER COMBINATIONS LIMITED TO ONE PER 365 DAYS
5681	ANESTHESIA AND SURGICAL PROCEDURE NOT PAYABLE ON SAME DATE OF SERVICE
5682	LIMIT - DURABLE MEDICAL EQUIPMENT (DME) REQUIRES PRIOR AUTHORIZATION (PA) FOR 1ST MONTH OF RENTAL
5683	PREGNANCY RELATED SERVICES LIMITED TO ONE PER 90 DAYS
5684	TWO PER LIFETIME (ONE PER SIDE) - BILATERAL
5685	30 PER THREE CALENDAR MONTHS (90 DAYS)
5686	TWO PER EYE PER CALENDAR YEAR-BILATERAL
5687	SERVICES NOT COMPENSABLE FOR WAV11

5688	PROCEDURE LIMITED TO 16 PER 30 DAYS
5689	PROCEDURES LIMITED TO 60 PER CALENDAR MONTH
5690	PROCEDURE LIMITED TO ONE PER 1,095 DAYS (THREE YEARS) - GRP
5691	T1015/U9 IS NOT COMPENSABLE FOR HEALTH CARE BENEFIT PACKAGE (HCBP) 12 & 15
5692	DENTAL ENCOUNTER PH MANAGED CARE ORGANIZATION (MCO) REVIEW
5693	OUT PATIENT SERVICES REQUIRE MANUAL PRICING
5694	TECHNICAL & PROFESSIONAL OR TOTAL COMPONENT - LIMIT TO TWO PER 365 DAYS
5695	DELIVERIES LIMITED TO ONE PER 183 DAYS
5696	SPECIAL PHARMACEUTICAL BENEFIT PROGRAM (SPBP) SERVICES NOT COMPENSABLE IN PLACE OF SERVICE (POS) 21, 31, & 32
5697	FEDERALLY QUALIFIED HEALTH CENTER (FQHC) / RURAL HEALTH CLINIC (RHC) MAY ONLY BILL A COMPLETE EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SCREEN
5698	TECHNICAL COMPONENT (TC) OR TOTAL COMPONENT REQUIRES PRIOR AUTHORIZATION (PA) DATE OF SERVICE (DOS) ON OR AFTER 09/01/08
5699	SELECT ENTERAL CODES REQUIRE PRIOR AUTHORIZATION (PA) OR ATTACHMENT
5700	CLAIM ADJUSTMENT SUSPENDED FOR MANUAL REVIEW
5701	EXCEEDED LIMITS OF FOUR SERVICES FOR ANY COMBINATION OF PROCEDURE CODES
5702	BILLING DENTURE RELINES / ADJUST - 180 DAYS FROM INSERTION
5703	DATE OF SERVICE (DOS) ON INVOICE IS AN IMPOSSIBLE CALENDAR DATE
5704	CLAIM SUSPENDED TO VERIFY MEDICARE DEDUCTIBLE - ON APPROVED CLAIM
5705	PLACE OF SERVICE REVIEW (PSR) NUMBER CANNOT BE FOUND ON THE DEPARTMENT'S RECORDS
5706	FOR DEPARTMENT'S INFORMATION ONLY
5707	DENTAL CODES LIMITED TO ONE PER LIFETIME
5709	ORTHO LIMITED TO SEVEN PER LIFETIME
5710	PROCEDURE CODES LIMITED TO A TOTAL OF ONE PER 90 DAYS
5711	PROCEDURE CODE LIMITED TO FIVE PER PROVIDER PER 365 DAYS (31)
5712	PROCEDURE CODE LIMITED TO FIVE PER PROVIDER PER 365 DAYS (19)
5713	PROCEDURE CODE LIMITED TO FIVE PER PROVIDER PER 365 DAYS (27)
5714	PROCEDURE CODE LIMITED TO FIVE PER PROVIDER PER 365 DAYS (17)
5715	PROCEDURE CODE LIMITED TO FIVE PER PROVIDER PER 365 DAYS (21)
5716	PROCEDURE CODE LIMITED TO FIVE PER PROVIDER PER 365 DAYS (20)
5717	PROCEDURE LIMITED TO FOUR PER CALENDAR YEAR PER PROVIDER
5718	ONE PER TOOTH PER LIFETIME - EXTRACTIONS
5721	No Waiver Rate Found for the Procedure Code/Modifiers combination
5722	SERVICE LIMITED TO ONE PER CALENDAR MONTH - GRPLMT
5723	PROCEDURE LIMITED TO ONE PER 1,095 DAYS - GRP (SAME PROVIDOR)
5724	RENTAL OF DURABLE MEDICAL EQUIPMENT (DME) EXCEEDS THREE MONTHS - OCCURRENCE
5725	ONLY ONE PROFESSIONAL & FACILITY PAYMENT/TRIMESTER
5726	DURABLE MEDICAL EQUIPMENT (DME) LIMITED TO ONE PER 365 DAYS

5727	HOSPICE ROUTINE HOME CARE MUST BE BILLED AT LOW RATE
5728	HOSPICE SIA PAYMENT EXCEEDED SEVEN DAY LIMIT.
5729	HOSPICE SIA PAYMENT LIMITED TO 16 UNITS PER DAY
5730	Limit Over 56 Units But Not Cutback
5731	Limited To 200 Units / 50 Hours Per Calendar Week
5732	Limited To 104 Units / 26 Hours Per Fiscal Year
5733	Limited To 40 Units / 10 Hours Per Fiscal Year
5734	Limited To 160 Units / 40 Hours Per Fiscal Year
5735	Limited To 48 Units / 12 Hours Per Fiscal Year
5736	Limited To 80 Units / 20 Hours Per Fiscal Year
5737	Limited To $500 Per Participant Per Fiscal Year
5738	Limited To 640 Units /160 Hours Per Fiscal Year
5739	SUSPENDED BY THE OFFICE OF DEVELOPMENTAL PROGRAMS (ODP) FOR MANUAL REVIEW
5772	HEALTHY BEGINNINGS PLUS (HBP) FIRST TRIMESTER LIMITED TO ONE PER 180 DAYS
5773	HEALTHY BEGINNINGS PLUS (HBP) SECOND TRIMESTER LIMITED TO ONE PER 180 DAYS
5774	SERVICES LIMITED TO ONE VISIT PER DAY
5775	START-UP AND TRANSITION FEE PER PROVIDER PER RECIPIENT IDENTIFICATION
5776	START-UP OR TRANSITION FEE PER PROVIDER PER RECIPIENT IDENTIFICATION
5777	NO SERVICE WHEN ADMINISTRATION FEE BILLED
5778	MULTI ADMINISTRATION FEE ON CLAIM
5779	ADMINISTRATION FEE AND SERVICE NOT IN SAME MONTH
5780	START-UP BILLED WITH ANOTHER ADMINISTRATION FEE IN SAME MONTH
5781	TRANSITION LIMIT ONE PER LIFETIME PER PARTICIPANT
5782	MULTI SERVICES ON CLAIM FOR ADMINISTRATION FEE - DIFFERENT MONTH
5783	CANNOT BILL STARTUP FEE
5784	ONE MONTHLY ADMINISTRATION FEE ALLOWED PER MONTH PER CONSUMER
5785	PROCEDURE CODE LIMITED TO ONE PER FLU SEASON
5786	PROCEDURE CODE LIMITED TO ONE PER FLU SEASON
5797	MORE THAN 36 MONTHS OXYGEN EQUIPMENT/ACCESORY RENTAL
5798	36 OXYGEN EQUIPMENT/ACCES RENTAL PAYMENTS WITHIN FIVE YEARS
5799	FUNERAL DIRECTOR SERVICES MAY NOT BE DIRECT BILLED
5800	YOU HAVE BILLED FOR AN EMERGENCY ROOM SERVICE AND AN INPATIENT SERVICE ON THE SAME DAY FOR THE SAME PRIMARY DIAGNOSIS
5801	THE FEE FOR SURGERY PERFORMED IN AN EMERGENCY ROOM OR HOSPITAL INCLUDES FOLLOW UP CARE DURING HOSPITALIZATION.
5802	THE INVOICE CLAIM LINE AND ONE PAID PREVIOUSLY HAVE THE SAME RECIPIENT AND THE SAME DATE OF SERVICE. ONE INDICATES THE TYPE OF SERVICE - PARTIAL HOSPITALIZATION AND THE OTHER INDICATES THE TYPE OF SERVICE - PSYCHIATRIC.
5803	THE EMERGENCY ROOM PHYSICIAN COMPONENT HAS BEEN BILLED MORE THAN ONCE ACCORDING TO THE DEPARTMENT'S RECORDS.
5804	BILATERAL PROCEDURE LIMITED TO ONE PER LIFETIME

5805	SERVICE NOT COVERED FOR RECIPIENTS BENEFIT PACKAGE
5806	RESERVED FOR FUTURE USE
5840	COMPLETE/PARTIAL DENTURE LIMIT TO ONE PER ARCH PER FIVE YEARS
5841	ONE DENTURE PER ARCH PER LIFETIME
5842	PROPHYLAXIS LIMITED TO ONE PER 180 DAYS - ADULT
5843	ORAL EXAMS LIMITED TO ONE PER 180 DAYS
5844	BACKUP RENAL DIALYSIS LIMITED TO 75 PER YEAR
5845	PROCEDURES LIMITED TO FOUR PER CALENDAR YEAR
5846	PROCEDURES LIMITED TO TWO PER TWO CALENDAR YEARS
5847	SERVICE LIMITED TO 70 UNITS PER CALENDAR YEAR PER RECIPIENT
5850	PHYSICIAN OFFICE VISIT LIMIT FOUR PER CALENDAR YEAR
5851	BACKUP RENAL DIALYSIS LIMITED TO 75 PER YEAR
5852	CRNP (CERTIFIED REGISTERED NURSE PRACTITIONER) LIMITED TO THREE VISITS PER CALENDAR YEAR
5856	INDEPENDENT CLINIC LIMIT FIVE VISITS PER CALENDAR YEAR
5857	OUTPATIENT HOSPITAL CLINIC LIMIT NINE VISITS PER CALENDAR YEAR
5859	PODIATRIST VISIT LIMITS TO FOUR PER CALENDAR YEAR
5861	CHIROPRACTOR SERVICES LIMITED TO NINE PER CALENDAR YEAR
5862	CHIROPRACTOR SERVICES LIMITED TO TEN PER CALENDAR YEAR
5863	OPTOMETRIST SERVICES LIMITED TO ONE PER CALENDAR YEAR
5865	OPTOMETRIST SERVICES LIMITED TO TWO PER CALENDAR YEAR
5867	OUTPATIENT SURGERY SPECIAL PROCEDURE UNIT (SPU) LIMITED TO FIVE PER YEAR
5869	OUTPATIENT AMBULATORY SURGICAL CENTER (ASC) LIMITED TO TWO PER YEAR
5870	BACKUP RENAL DIALYSIS PROCEDURES LIMITED TO 26 PER YEAR
5884	CLOZAPINE LIMITED TO ONE PER WEEK
5885	PSYCHIATRIC PARTIAL HOSPITALIZATION - 540 HOURS PER CALENDAR YEAR - CUTBACK
5886	PSYCHIATRIC PARTIAL HOSPITALIZATION - 540 HOURS PER CALENDAR YEAR
5888	PROCEDURES LIMITED TO ONE PER TWO CALENDAR YEARS
5889	PROCEDURES LIMITED TO ONE PER CALENDAR YEAR
5896	ICF-ID/ORC (INTERMEDIATE CARE FACILITY/INTELLECTUALLY DISABLED/OTHER RELATED CONDITIONS) NOT COVERED FOR RECIPIENT'S PACKAGE
5900	STANDARD BUDGET EXCEPTION FOR PROFESSIONAL / OUTPATIENT CLAIMS
5902	BUDGET LIMIT EXCEPTION (BLE) APPROVED - PRACTITIONER, PSYCHIATRIC SERVICES
5903	ADULT ACUTE CARE BUDGET LIMIT (INACTIVE)
5904	GENERAL ASSISTANCE (GA) ACUTE CARE - BUDGET LIMIT
5905	ADULT INPATIENT REHABILITATION - BUDGET LIMITS
5906	GENERAL ASSISTANCE (GA) INPATIENT REHABILITATION - BUDGET LIMITS
5907	BUDGET EXCEPTION - RENDERING IS IN PRIMARY CARE PROVIDER (PCP) GROUP

5908	BUDGET EXCEPTION - REFERRING PHYSICIAN IS PRIMARY CARE PROVIDER (PCP)
5909	ADULT VISIT LIMIT - BUDGET LIMITS
5910	GENERAL ASSISTANCE (GA) VISIT LIMITS - BUDGET LIMITS
5911	VISIT LIMIT MET - ELIGIBILITY VERIFICATION SYSTEM (EVS) VALIDATED
5912	1ST CLAIM OVER $5,000 DURABLE MEDICAL EQUIPMENT (DME) - BUDGET LIMIT (INACTIVE)
5913	ACCESSORY FOR PAID DURABLE MEDICAL EQUIPMENT (DME) - BUDGET LIMITS (INACTIVE)
5914	DURABLE MEDICAL EQUIPMENT (DME) FOR WAIVER - BUDGET LIMITS (INACTIVE)
5915	ADULT DURABLE MEDICAL EQUIPMENT (DME) - BUDGET LIMITS (INACTIVE)
5916	GENERAL ASSISTANCE (GA) DURABLE MEDICAL EQUIPMENT (DME) - BUDGET LIMITS (INACTIVE)
5917	ADULT AMBULATORY SURGICAL CENTER (ASC) / SPECIAL PROCEDURE UNIT (SPU) - BUDGET LIMIT (INACTIVE)
5918	PHARMACY SIX (RX) PER MONTH BENEFIT LIMIT EXCEEDED
5919	SUPER PRIOR AUTHORIZATION (PA) REQUIRED FOR EXCEPTIONS TO GENERAL ASSISTANCE (GA) PRESCRIPTION
5920	PHARMACY (RX) LIMIT EXCEEDED EMERGENCY EXCEPTION
5921	PRESCRIPTION MAXIMUM EXCEEDED GENERAL ASSISTANCE (GA) EMERGENCY SERVICE
5922	PHARMACY (RX) LIMIT EXCEEDED PREGNANCY EXCEPTION
5923	PRESCRIPTION MAX EXCEEDED GENERAL ASSISTANCE (GA) PREGNANCY SERVICE
5924	PHARMACY (RX) LIMIT EXCEEDED PREGNANCY HISTORY CLAIM EXCEPTION
5925	PRESCRIPTION MAX EXCEEDED GENERAL ASSISTANCE (GA) CLINICAL EXCEPTION
5926	PHARMACY (RX) EXCEEDED CLINICAL EXCEPTION
5927	GENERAL ASSISTANCE (GA) AMBULATORY SURGICAL CENTER (ASC) / SPECIAL PROCEDURE UNIT (SPU) - BUDGET LIMITS (INACTIVE)
5928	INPATIENT PSYCHOLOGICAL LIMITED TO 30 DAYS PER FISCAL YEAR (FY) - CUTBACK
5929	INPATIENT PSYCHOLOGICAL LIMITED TO 30 DAYS
5930	INPATIENT PSYCHOLOGICAL LIMITED TO 30 DAYS - GENERAL ASSISTANCE (GA)
5931	OUTPATIENT CLINIC PSYCHOTHERAPY LIMIT TO FIVE HOURS PER 30 DAYS
5932	PSYCHOLOGICAL OUTPATIENT LIMIT FIVE HOUR PER 30 DAYS - ADULT
5933	PSYCHOLOGICAL OUTPATIENT LIMIT FIVE HOURS PER 30 DAYS - GENERAL ASSISTANCE (GA)
5934	PSYCHOLOGICAL PARTIAL HOSPITALIZATION - 540 HOURS PER FISCAL YEAR - CUTBACK
5935	PSYCHOLOGICAL PARTIAL HOSPITALIZATION - 540 HOURS PER FISCAL YEAR - ADULT
5936	PSYCHOLOGICAL PARTIAL HOSPITALIZATION - 540 HOURS PER FISCAL YEAR - GENERAL ASSISTANCE
5937	RECIPIENT IS NEAR $10,000 OTHER MEDICAL EXPENSES (OME) LIMIT
5938	RECIPIENT HAS MET $10,000 OTHER MEDICAL EXPENSES (OME) LIMIT
5939	PHARMACY (RX) LIMIT ACCUMULATION
5940	STANDARD BUDGET EXCEPTION FOR INSTITUTIONAL CLAIMS
5941	BUDGET LIMIT EXCEPTION FOR AUTOMATED UTILIZATION REVIEW (AUR)
5942	PHARMACY (RX) LIMIT EXCEEDED AGE EXCEPTION
5943	PHARMACY (RX) LIMIT EXCEEDED DUAL/PART B EXCEPTION

5944	PHARMACY (RX) LIMIT EXCEEDED LONG TERM CARE (LTC) / INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR) EXCEPTION
5945	PHARMACY (RX) LIMIT EXCEEDED DURABLE MEDICAL EQUIPMENT (DME) EXCEPTION
5950	PSYCHOTHERAPY LIMITED TO 480 MINUTES PER 30 DAYS
5951	CLAIM EXCEEDS 480 MINUTE PSYCHOTHERAPY LIMIT
5952	PSYCHOTHERAPY LIMITED TO 420 MINUTES PER 30 DAYS
5953	CLAIM EXCEEDS 420 MINUTE PSYCHOTHERAPY LIMIT
5954	PSYCHOLOGICAL TESTING LIMIT / $80.00 PER 365 DAYS
5955	PAYMENT FOR SERVICE LIMITED TO ONE PER WEEK
5956	FAMILY BASED MENTAL HEALTH SERVICES LIMITED TO 32 WEEKS
5957	EIGHT WEEK LIMIT MET DURING NON-PSYCHIATRIC ADMISSION / PLACE OF SERVICE (POS) 21
5958	EIGHT WEEK LIMIT MET NON-PSYCHIATRIC ADMISSION IN PLACE OF SERVICE (POS) 31 OR 32
5959	ART THERAPY LIMITED TO FIVE HOURS PER SEVEN DAYS
5960	RECIPIENT WAS NOT DISCHARGED TO HOME OR COMMUNITY
5961	CLAIM EXCEEDS $80 PSYCHOLOGICAL TESTING LIMIT
5962	DIAGNOSTIC / PSYCHOLOGICAL EVALUATION LIMITED TO 3 PER 365 DAYS
5963	DIAGNOSTIC / PSYCHOLOGICAL EVALUATION LIMITED TO 3 PER 365 DAYS
5970	CHILDHOOD NUTRITION AND WEIGHT MANAGEMENT SERVICES (CNWMS) AND EVALUATION & MANAGEMENT (E&M) VISIT NOT PAID ON SAME DAY/SAME DX.
5971	CHILDHOOD NUTRITION AND WEIGHT MANAGEMENT SERVICES (CNWMS) INITIAL ASSESSMENT LIMITED THREE PER 365 DAYS.
5972	CHILDHOOD NUTRITION AND WEIGHT MANAGEMENT SERVICES (CNWMS) REASSESSMENTS LIMITED TO FOUR PER 365 DAYS
5973	CHILDHOOD NUTRITION AND WEIGHT MANAGEMENT SERVICES (CNWMS) INITIAL ASSESSMENT MUST BE PAID IN HISTORY
5974	CHILDHOOD NUTRITION AND WEIGHT MANAGEMENT SERVICES (CNWMS) COUNSELING LIMITED TO 24 UNITS PER 365 DAYS
5975	CHILDHOOD NUTRITION AND WEIGHT MANAGEMENT SERVICES (CNWMS) NUTRITION COUNSEL LIMIT 12 UNITS PER 365 DAYS.
5976	PROPHYLAXIS LIMITED TO ONE PER 180 DAYS - ADULT
5977	ORAL EXAMS LIMITED TO ONE PER 180 DAYS - ADULT
5978	ENDODONTIC SERVICES NOT COVERED FOR ADULTS
5979	PERIDONTAL SERVICES NOT COVERED FOR ADULTS
5980	CROWN & ADJUNCTIVE SERVICES NOT COVERED FOR ADULTS
5981	ONE DENTURE PER ARCH PER LIFETIME - ADULT LIMIT
5983	LARC BILLED ON AN OUTPATIENT CLAIM
5984	ELIGIBLE BED RES. DAYS LIMITED TO 60 PER FISCAL YEAR
5985	INELIGIB BED RES. DAYS LIMITED TO 60 PER FISCAL YEAR
5986	OBS G CODES: PAYABLE TO OP HOSPITALS ONLY
5987	G0379 PAID MORE THAN ONCE PER ROLLING 3 DAYS
5988	ANCILLARY & DIAGNOSIS SERVICES OR OBSERVATION: MANUAL REVIEW
5989	ANCILLARY & DIAGNOSIS SERVICES OR OBSERVATION MAY BE PAID
5990	PT/OT/ST NOT COMPENSABLE WHEN PROVIDED DURING OBSERVATION

5991	OBSERVATION FLAT FEE PAID MORE THAN 1 PER 3 DAYS
5992	SERVICES LIMITED TO ONE PER DAY FOR OBSERVATION
5993	INPATIENT STAY OR OBSERVATION PAID - NOT BOTH
5994	OBSERVATION VISITS LIMITED TO 1 PER DAY
5995	T1029 REQUIRES A DIAGNOSIS RELATED TO LEAD TOXICITY
5996	T1029 PRIMARY DIAGNOSIS MUST BE RELATED TO LEAD TOXICITY
5997	RECIPIENT HEALTH CARE BENEFIT PACKAGE (HCBP) DOES NOT COVER SERVICE FOR DATE OF SERVICE (DOS)
5998	MA (Medical Assistance) FEE IS GREATER THAN THE ACA (AFFORDABLE CARE ACT) PCS RATE
5999	PROCEDURE 90999 FOR MEDICARE B/MEDICARE ADVANTAGE COST SHARING
6000	MANUAL PRICING REQUIRED
6001	EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) INFANT COMPLETE SCREEN LIMITS
6002	EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) YOUTH COMPLETE SCREEN LIMITS
6003	EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) OPTIONAL PRIOR TO COMPLETE SCREEN
6004	EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) COMPLETE SCREEN PRIOR TO OPTIONAL
6005	CLINIC VISIT / ENCOUNTER LIMITED TO ONE PER DAY
6006	VENT SERVICES FOR LONG TERM CARE (LTC) CLIENTS SUSPENDED FOR REVIEW
6007	DIAGNOSIS Z0000, Z0001, Z00110, Z00111, Z00121, Z00129, Z761 OR Z762 REQUIRED FOR EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SCREENS
6008	MODIFIER 'EP' REQUIRED ON EVALUATION & MANGEMENT (E&M) CODE FOR EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SCREENS
6009	REFERRAL CODE 'YD' MISSING ON EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SCREEN
6010	RURAL HEALTH CLINIC (RHC) / FEDERALLY QUALIFIED HEALTH CENTER (FQHC) DIAGNOSIS Z0000, Z0001, Z00110, Z00111, Z00121, Z00129, Z761 OR Z762 REQUIRED FOR EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SCREENS
6011	MODIFIER 'EP' REQUIRED ON ALL COMPONENTS COMPLETE EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SCREENS
6012	REFERRAL CODE 'YD' MISSING ON EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SCREEN RURAL HEALTH CLINIC (RHC) / FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
6013	T1015 / 'EP' NOT ON THE FIRST CLAIM LINE
6100	RESERVED
6101	RESERVED
6102	RESERVED
6103	RESERVED
6104	RESERVED
6105	RESERVED
6106	RESERVED
6107	RESERVED
6108	RESERVED
6109	RESERVED
6110	RESERVED

6111	RESERVED
6112	RESERVED
7000	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT
7001	INFORMATIONAL PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT
7002	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR LATE REFILL
7003	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR DRUG
7004	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR THERAPEUTIC DUPLICATION
7005	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR PREGNANCY
7006	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR EARLY REFILL
7007	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR HIGH DOSE
7008	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR PEDIATRIC AGE
7009	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR GERIATRIC AGE
7010	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR LOW DOSE
7011	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR MINIMUM DURATION
7012	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR MAXIMUM DURATION
7013	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR DRUG DISEASE
7014	CLAIM FAILED A PROSPECTIVE DRUG UTILIZATION REVIEW (PRODUR) ALERT FOR INGREDIENT DUPLICATION
7015	NO OVERRIDE INFORMATION ON CLAIM
7016	DRUG UTILIZATION REVIEW (DUR) CANCELLATION PROCESSED
7017	BYPASS OF EMERGENCY ROOM ALERT FOR EMERGENCY SUPPLY
7024	LONG TERM CARE (LTC), PRIVATE INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF/MR) RECIPIENT - NON-COMPENSABLE DRUG
7027	DRUG QUANTITY PER DAY LIMIT HAS BEEN EXCEEDED
7099	DRUG UTILIZATION REVIEW (DUR) PLUS RENEWAL BYPASS
7100	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED LIPOTROPICS (STATINS)
7101	DRUG UTILIZATION REVIEW (DUR) PLUS LIPITOR 80 MG
7102	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED DRUG LIST BENZODIAZEPINES - AGE 0 - 20
7103	DRUG UTILIZATION REVIEW (DUR) PLUS PREFERRED BENZODIAZEPINES - AGE 0 - 20
7104	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED BENZODIAZEPINES - AGE GREATER THAN 21
7106	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED ANTIHISTAMINE
7107	DRUG UTILIZATION REVIEW (DUR) PLUS PREFERRED OVER THE COUNTER ANTIHISTAMINE FOR DUAL ELIGIBLE
7108	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED ANTIDEPRESSANTS (SSRIs)
7109	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED ORAL BETA-AGONIST
7110	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED SHORT-ACTING BETA-AGONIST INHALATION SOLUTION
7111	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED SHORT-ACTING BETA-AGONIST INHALERS
7112	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED LONG-ACTING BETA-AGONIST INHALATION SOLUTION
7113	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED INTRANASAL RHINITIS

7114	DRUG UTILIZATION REVIEW (DUR) PLUS PREFERRED COSMETIC ACNE AGENTS
7115	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED NON-COSMETIC ACNE AGENTS (EXCLUDES COMBINATION PRODUCTS)
7116	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED COSMETIC ACNE AGENTS - AGE 0 - 20
7117	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED COSMETIC ACNE AGENTS - AGE 21 - 120
7118	DRUG UTILIZATION REVIEW (DUR) PLUS SPIRIVA
7119	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED NSAID (EXCLUDING CELEBREX)
7120	DRUG UTILIZATION REVIEW (DUR) PLUS CELEBREX
7121	DRUG UTILIZATION REVIEW (DUR) PLUS PREFERRED NSAID
7122	DRUG UTILIZATION REVIEW (DUR) PLUS RESTASIS
7123	DRUG UTILIZATION REVIEW (DUR) PLUS SUBOXONE/SUBUTEX
7124	DRUG UTILIZATION REVIEW (DUR) PLUS PREFERRED SUBOXONE CONTRAINDICATED MEDICATION
7125	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED STIMULANTS
7126	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED DRUG LIST (PDL) SUBOXONE CONTRAINDICATED MEDICATION
7127	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED SUBOXONE CONTRAINDICATED MEDICATION
7128	NON-PREFERRED DRUG LIST (PDL) BENZODIAZEPINES AND SUBOXONE/SUBUTEX CHECK
7129	PREFERRED BENZODIAZEPINES AND SUBOXONE/SUBUTEX CHECK AGE 21 - 120
7130	NON-PREFERRED BENZODIAZEPINES AND SUBOXONE/SUBUTEX CHECK
7131	DRUG UTILIZATION REVIEW (DUR) PLUS DAYTRANA
7132	DRUG UTILIZATION REVIEW (DUR) PLUS LIQUADD
7133	DRUG UTILIZATION REVIEW (DUR) PLUS NUVIGIL
7134	DRUG UTILIZATION REVIEW (DUR) PLUS PROVIGIL
7135	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED PROTON PUMP INHIBITOR (PPI) - AGE 13 - 120
7136	DRUG UTILIZATION REVIEW (DUR) PLUS PREFERRED PROTON PUMP INHIBITOR (PPI) - AGE 0 - 5
7137	DRUG UTILIZATION REVIEW (DUR) PLUS OVER THE COUNTER (OTC) PROTON PUMP INHIBITOR (PPI) FOR DUAL ELIGIBLE
7138	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED PROTON PUMP INHIBITOR (PPI) - AGE 0 - 5
7139	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED DRUG - PRIOR AUTHORIZATION REQUIRED
7140	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED PANCREATIC ENZYMES
7141	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED EVISTA
7142	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED SHORT-ACTING INHALER
7143	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED INHALATION SOLUTION
7144	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED LONG-ACTING INHALER
7145	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED SEREVENT
7146	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED INTRANASAL RHINITIS
7147	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED VERAMYST
7148	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED PHENYTEK
7149	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED FELBATOL
7150	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED STAVZOR

7151	DRUG UTILIZATION REVIEW (DUR) PLUS LYRICA
7152	DRUG UTILIZATION REVIEW (DUR) PLUS PREFERRED TOPAMAX/TOPIRAMATE (TAMIFLU)
7153	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED SKELETAL MUSCLE RELAXANTS
7154	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED AZASAN
7155	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED CYCLOSPORINE
7156	DRUG UTILIZATION REVIEW (DUR) PLUS MYFORTIC
7157	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED TACROLIMUS
7158	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED MULTIPLE SCLEROSIS
7159	DRUG UTILIZATION REVIEW (DUR) PLUS REVATIO
7160	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED ADCIRCA
7161	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED PROTON PUMP INHIBITOR (PPI) AGE 6 - 12
7162	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED PREVACID SOLUTAB & NEXIUM/PROTONIX SUSPENSION AGE 6-12
7163	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED SAVELLA
7164	DRUG UTILIZATION REVIEW (DUR) PLUS CYMBALTA
7165	DRUG UTILIZATION REVIEW (DUR) PLUS ZORTRESS
7166	DRUG UTILIZATION REVIEW (DUR) PLUS NPD CHLORAL HYDRATE AGE 0 -11
7167	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED ANTIPARKINSON'S
7168	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED ACTONEL
7169	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED BONIVA
7170	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED BUDESONIDE/PULMICORT RESPULES
7171	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED ANTIPSYCHOTICS
7172	DRUG UTILIZATION REVIEW (DUR) PLUS NPD ROSIGLITAZONE
7173	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 ANDROGENIC AGENT
7174	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 ACE/ARB INHIBITOR
7175	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 ARB
7176	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 SSRI
7177	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 ANTIHISTAMINE
7178	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 ATYP ANTIPSYCHOTIC
7179	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 LONG-ACTING BENZO
7180	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 SHORT-ACTING BENZO
7181	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 BETA BLOCKER
7182	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 CALC. CHAN. BLOCKER
7183	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 INH GLUCOCORTICOID
7184	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIREDMORE THAN 1 STATIN
7185	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 LONG-ACTING BETA AGON
7186	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 LONG-ACTING OPIOID
7187	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 PPI

7188	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 TRIPTAN
7189	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 LONG-ACTING STIMULANT
7190	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 SHORT-ACTING STIMULANT
7191	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 SKEL. MUS. RELAXANT
7192	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED MORE THAN 1 NSAID
7193	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED GABAPENTIN PLUS PREGABALIN
7194	DRUG UTILIZATION REVIEW (DUR) PLUS NPD PPI AGE 6 - 120
7195	DRUG UTILIZATION REVIEW (DUR) PLUS NPD REVATIO AGE 0 - 17
7196	DRUG UTILIZATION REVIEW (DUR) PLUS NPD REVATIO AGE 18 - 120
7197	DRUG UTILIZATION REVIEW (DUR) PLUS ADCIRCA AGE 18 - 120
7198	DRUG UTILIZATION REVIEW (DUR) PLUS NPD CELLCEPT
7199	DRUG UTILIZATION REVIEW (DUR) PLUS NPD TYVASO
7200	DRUG UTILIZATION REVIEW (DUR) PLUS NPD HIV MEDICATION
7201	DRUG UTILIZATION REVIEW (DUR) PLUS PROMETHAZINE AGE 0 - 5
7202	DRUG UTILIZATION REVIEW (DUR) PLUS NPD CEFDINIR CAPSULES AGE 0 - 17
7203	DRUG UTILIZATION REVIEW (DUR) PLUS NPD XIFAXAN 550MG
7204	DRUG UTILIZATION REVIEW (DUR) PLUS ULCERATIVE COLITIS
7205	DRUG UTILIZATION REVIEW (DUR) PLUS ADULT AGE EDIT, STIMULANTS AND RELATED
7206	DRUG UTILIZATION REVIEW (DUR) PLUS ADULT AGE EDIT, ANTIPSYCHOTIC
7207	DRUG UTILIZATION REVIEW (DUR) PLUS NP EQUETRO
7208	DRUG UTILIZATION REVIEW (DUR) PLUS ORAL KETOROLAC
7209	DRUG UTILIZATION REVIEW (DUR) PLUS INJECTABLE KETOROLAC AGE 2-16
7210	DRUG UTILIZATION REVIEW (DUR) PLUS INJECTABLE KETOROLAC AGE 17-120
7211	DRUG UTILIZATION REVIEW (DUR) PLUS INJECTABLE KETOROLAC AGE 0-1
7212	DRUG UTILIZATION REVIEW (DUR) PLUS NASAL KETOLOAC
7213	DRUG UTILIZATION REVIEW (DUR) PLUS NP CHANTIX
7214	DRUG UTILIZATION REVIEW (DUR) PLUS: PRIOR AUTHORIZATION REQUIRED FOR DRUG/DRUG INTERACTION
7215	DRUG UTILIZATION REVIEW (DUR) PLUS ORAL ONCOLOGY AGENTS
7216	DRUG UTILIZATION REVIEW (DUR) PLUS NPD SSRI LIQUIDS AGE 0-15
7217	DRUG UTILIZATION REVIEW (DUR) PLUS NPD SSRI AGE 0-15
7218	DRUG UTILIZATION REVIEW (DUR) PLUS PIT SUPP AGENTS, LHRH
7219	DRUG UTILIZATION REVIEW (DUR) PLUS NPD DITROPAN XL AGE 0-17
7220	DRUG UTILIZATION REVIEW (DUR) PLUS NPD ALBUTEROL NEBS AGE 0-1
7221	DRUG UTILIZATION REVIEW (DUR) PLUS ANTIPSYCHOTICS, LOW DOSE
7222	DRUG UTILIZATION REVIEW (DUR) PLUS PIOGLITAZONE
7223	DRUG UTILIZATION REVIEW (DUR) PLUS ANTICOAGULANT DURATION
7224	DRUG UTILIZATION REVIEW (DUR) PLUS MONTELUKAST GRANULE PACK AGE 0-1

7225	DRUG UTILIZATION REVIEW (DUR) PLUS NPD FARESTON
7226	DRUG UTILIZATION REVIEW (DUR) PLUS MIRENA QUANTITY LIMIT
7227	PRIOR AUTHORIZATION (PA) REQUIRED: MORE THAN 1 COPD (ANTICHOLINERGIC) AGENT
7228	PRIOR AUTHORIZATION (PA) REQUIRED: MORE THAN 1 SHORT-ACTING BETA AGONIST FOUND
7229	PRIOR AUTHORIZATION (PA) REQUIRED: MORE THAN 1 BLADDER RELAXANT FOUND
7230	PRIOR AUTHORIZATION (PA) REQUIRED: MORE THAN 1 TYPICAL ANTIPSYCHOTIC FOUND
7231	PRIOR AUTHORIZATION (PA) REQUIRED: MORE THAN 1 SHORT-ACTING NARCOTIC FOUND
7232	DRUG UTILIZATION REVIEW (DUR) PLUS ADCIRCA AGE 0-17
7233	DRUG UTILIZATION REVIEW (DUR) PLUS: WARFARIN & PRADAXA IN COMBINATION
7234	DRUG UTILIZATION REVIEW (DUR) PLUS: GLUCOMETER QUANTITY LIMIT
7235	DRUG UTILIZATION REVIEW (DUR) PLUS: CLINICAL PRIOR AUTHORIZATION REQUIRED
7236	PRIOR AUTHORIZATION REQUIRED: MULTIPLE NARCOTIC PRESCRIPTION (RX)
7237	PRIOR AUTHORIZATION REQUIRED: MULTIPLE BENZODIAZEPINE PRESCRIPTION (RX)
7238	DRUG UTILIZATION REVIEW (DUR) PLUS NATROBA STEP THERAPY
7239	PRIOR AUTHORIZATION REQUIRED: SHORT ACTING NARCOTIC ANALGESIC AGE EDIT
7240	PRIOR AUTHORIZATION REQUIRED: LONG ACTING NARCOTIC ANALGESIC AGE EDIT
7241	PRIOR AUTHORIZATION REQUIRED: CODEINE AND NARCOTIC COUGH MEDS AGE EDIT
7242	DRUG UTILIZATION REVIEW (DUR): PLUS PRIOR AUTHORIZATION REQUIRED MORE THAN 1 ORAL ANTICOAGULANT
7243	DRUG UTILIZATION REVIEW (DUR): PLUS PRIOR AUTHORIZATION REQUIRED MORE THAN 1 INJECTABLE ANTICOAGULANT
7244	DRUG UTILIZATION REVIEW (DUR): PLUS PRIOR AUTHORIZATION REQUIRED MORE THAN 1 ALZHEIMER'S AGENT
7245	DRUG UTILIZATION REVIEW (DUR): PLUS PRIOR AUTHORIZATION REQUIRED MORE THAN 1 BPH AGENT
7246	DRUG UTILIZATION REVIEW (DUR): PLUS PRIOR AUTHORIZATION REQUIRED MORE THAN 1 PROTEASE INHIBITOR
7247	DRUG UTILIZATION REVIEW (DUR): PLUS PRIOR AUTHORIZATION REQUIRED MORE THAN 1 NNRTI
7248	DRUG UTILIZATION REVIEW (DUR): PLUS PRIOR AUTHORIZATION REQUIRED MORE THAN 1 LEUKOTRIENE MODIF
7249	DRUG UTILIZATION REVIEW (DUR) PLUS: NON-PRD ALZHEIMER'S AGENT
7250	DRUG UTILIZATION REVIEW (DUR) PLUS NPD ORAL ONCOLOGY AGENTS
7251	AUTHORIZATION REQUIRED BUPRENORPHINE 5 DAY EMERGENCY SUPPLY
7252	AUTHORIZATION REQUIRED SHORT-ACTING NARCOTIC 5 DAY EMERGENCY SUPPLY
7253	AUTHORIZATION REQUIRED LONG ACTING NARCOTIC 5 DAY EMERGENCY SUPPLY
7254	PRIOR AUTHORIZATION REQUIRED SHORT-ACTING NARCOTIC ANALGESIC
7255	PRIOR AUTHORIZATION REQUIRED LONG-ACTING NARCOTIC ANALGESIC
7256	PRIOR AUTHORIZATION REQUIRED ALZHEIMER'S AGENT
7257	DRUG UTILIZATION REVIEW (DUR) PLUS NITROFURANTION SUSPENSION AGE 0-8
7258	DRUG UTILIZATION REVIEW (DUR) PLUS ZOLPIDEM 10MG. AGE GREATER THAN 64
7259	PRIOR AUTHORIZATION (PA) REQUIRED HIV DUPLICATE THERAPY
7260	DRUG UTILIZATION REVIEW (DUR) PLUS THALIDOMIDE AND DERIVATIVES
7261	AUTHORIZATION REQUIRED XIFAXAN 5 DAY SUPPLY

7262	DRUG UTILIZATION REVIEW (DUR) PLUS VIVITROL CONTRAINDICATED MED
7263	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PRD METHYLPHENIDATE ER
7264	DRUG UTILIZATION REVIEW (DUR) PLUS NPD AMOXICILLIN/CLAV 250MG-62.5/5ML AGE LESS THAN ONE YEAR OLD
7265	DRUG UTILIZATION REVIEW (DUR) PLUS PROBUPHINE CONTRAINDICATED MED
7266	AUTHORIZATION REQUIRED NON-NARC BARBITURATE COMBO 5 DAY SUPPLY
7267	DRUG UTILIZATION REVIEW (DUR) PLUS DAY SUPPLY GREATER THAN 30 DAYS
7268	DRUG UTILIZATION REVIEW (DUR) PLUS LETROZOLE
7269	DRUG UTILIZATION REVIEW (DUR) PLUS EPANED SOLUTION AGE 0 - 5
7270	DRUG UTILIZATION REVIEW (DUR) PLUS QBRELIS SOLUTION AGE 0 - 8
7271	DRUG UTILIZATION REVIEW (DUR) PLUS NON-PREFERRED ATOMOXETINE
7272	VALIDATE THE NUMBER OF UNITS BILLED FOR AVASTIN
7273	DRUG UTILIZATION REVIEW (DUR) PLUS TAMIFLU PROPHYLAXIS
7274	PRIOR AUTHORIZATION REQUIRED TRAMADOL AGE EDIT
7275	DRUG UTILIZATION REVIEW (DUR) PLUS SEREVENT
7276	DRUG UTILIZATION REVIEW (DUR) PLUS: SL BUP + BZD/CNS DEPRESSANT - PA REQUIRED
7277	DRUG UTILIZATION REVIEW (DUR) PLUS EUCRISA
7500	BILLING PROVIDER ON PREPAYMENT REVIEW
7501	RECIPIENT IS LOCKED-IN TO A SPECIFIC PROVIDER
7502	PROVIDER NOT ELIGIBLE FOR MANAGEMENT LOCK IN FEE - DETAIL
7503	PROVIDER NOT ELIGIBLE FOR MANAGEMENT LOCK IN FEE - HEADER
7506	CLAIM CONTAINS A NON-OVERRIDABLE ALERT
7508	DENIAL OF PAYMENT ON NEW ADMISSIONS (DPNA) SANCTION ON FILE
7509	RENDERING PROVIDER ON PREPAYMENT REVIEW
7510	RECIPIENT LOCKED INTO A DIFFERENT PRESCRIBER
7511	CLAIM SUSPENDED FOR REVIEW OF THE MA 312
7512	COMPREHENSIVE METHADONE FOR HEALTH CARE BENEFIT PACKAGE (HCBP) 3, 5, & 7 ONLY
7513	BILLING PROVIDER ON PREPAYMENT REVIEW
7514	BILLING PROVIDER ON PREPAYMENT REVIEW
7515	RENDERING PROVIDER ON PREPAYMENT REVIEW
7516	REFERRING PROVIDER ON PREPAYMENT REVIEW
7517	REFERRING PROVIDER ON PREPAYMENT REVIEW
7518	BILLING PROVIDER ON SUSPENSION REVIEW
7519	BILLING PROVIDER ON SUSPENSION REVIEW
7520	RENDERING PROVIDER ON SUSPENSION REVIEW
7521	REFERRING PROVIDER ON SUSPENSION REVIEW
7522	REFERRING PROVIDER ON SUSPENSION REVIEW
8000	PA (PRIOR AUTHORIZATION) DATA INCOMPLETE

8001	HISTORICAL DRUG AUDIT DATA INCOMPLETE
8002	HISTORICAL DRUG UTILIZATION REVIEW (DUR) AUDIT DATA INCOMPLETE
8232	VOID TRANSACTION - RECIPIENT DATE OF DEATH MASS ADJUSTMENT
9000	BILLED AMOUNT EXCEEDS ALLOWED AMOUNT
9001	CLAIM PAID AMOUNT WAS CUTBACK FOR CO-PAY. AGE RESTRICTIONS
9003	CUTBACK FOR THIRD PARTY COVERAGE
9005	PATIENT PAY CUTBACK HAS BEEN APPLIED
9006	GENERAL ASSISTANCE (GA) DEDUCTIBLE CUTBACK HAS BEEN APPLIED
9007	PAYMENT REDUCED FOR MULTIPLE PROCEDURES ON SAME DATE OF SERVICE (DOS)
9008	DEPARTMENT OF EDUCATION PAYMENT REDUCED TO FEDERAL SHARE
9010	CLAIM DENIED DUE TO VOID REQUEST
9011	CLAIM DENIED BECAUSE AT LEAST ONE DETAIL LINE WAS DENIED
9012	CUTBACK FOR PRIVATE THIRD PARTY LIABILITY (TPL) DEDUCTIBLE/COINSURANCE
9013	LONG TERM CARE (LTC) HOLD/LEAVE DAYS ADJUSTMENT
9014	MEDICARE CO-PAY REIMBURSEMENT CLAIM CUTBACK
9015	FAMILY PLANNING NEGOTIATED RATE
9016	MEDICAL ASSISTANCE (MA) ALLOWED AMOUNT CUTBACK BY MEDICARE PAID AMOUNT
9017	BILLED AMOUNT IS LESS THAN PROVIDER SPECIFIC RATE
9018	CURRENT MULTI-UNIT LINE CONTAINS UNITS WHICH EXCEED ALLOWED UNITS.
9019	TOTAL AMOUNT CUTBACK DUE TO SUPPLEMENTAL SECURITY INCOME (SSI) PAYMENT
9020	MEDICARE ADVANTAGE - INACTIVE
9021	COPAY REDUCED DUE TO COUPON SUBMITTED
9022	MEDICARE PART B COST SHARING PAYMENT
9023	Usual & Customary amount/charge submitted is lower than the detail calculated allowed amount
9030	CO-PAY HAS BEEN ASSESSED FOR PH/95 - HEADER (INACTIVE)
9031	CO-PAY HAS BEEN ASSESSED FOR PH/95 - DETAIL (INACTIVE)
9105	LIPITOR GRANDFATHERED
9998	LIMIT AUDIT TRIGGER FOR AUDIT 5031 - FOUR units per 30 days only for pharmacy CLAIMs with dispense date on or after 2/7/2005
9999	LIMIT AUDIT TRIGGER FOR AUDIT 5031 - SIX units per 30 days only for pharmacy CLAIMs with dispense date on or after 2/7/2005
	Updated: May 11, 2018