Appendix R
Remittance Advice Messages

EOB Code	Description
0000	This claim/service is pending for program review.
0007	Information inadequate to establish medical necessity of procedure performed. Please resubmit with additional supporting documentation.
0010	The number of hospital visits exceeds the guidelines for the procedure billed.
0030	EPSDT services are not a benefit with office visits.
0039	The National Drug Code (NDC) is missing. The NDC is required for physician-administered drugs. Please reference the provider billing manuals and the following bulletins for more information: December 2007 #B070024, June 2008 #B0800249, May 2009 #B0900266.
0040	Rendering Provider ID is not on file.
0044	The provider is not authorized to perform or provide the service requested.
0067	The claim dates of service overlap the ICD version effective date. No overlap is allowed between ICD9 and ICD10. Claim must be split.
0074	Billing Provider is restricted from submitting electronic claims.
0091	A valid enrolled prescribing/referring/ordering provider NPI is required.
0100	Denied as duplicate claim. Services on this claim were previously partially paid or paid in full.
0101	This is a duplicate service.
0103	This is a duplicate item that was previously processed and paid, possibly to another provider.
0110	There is no additional benefit for this service. Payment for this procedure was included in the payment for the primary procedure.
0115	Unable To Process Your Adjustment Request.
0116	Procedure Code or Drug Code not a benefit on Date of Service.
0129	The member's State ID number is missing. Enter the member's State ID number listed on the eligibility inquiry.
0140	A new patient Nursing Facility (NF) visit is limited to one. A new NF visit was previously paid to this provider. Bill the appropriate established patient c
0150	Place of Service is Missing or Invalid
0162	The service is included in the FQHC/ RHC encounter rate. This service is not a separate benefit.
0165	The Medicare provider number is missing or invalid. Enter/Correct the Medicare provider number.
0169	The Medicare paid amount is missing or invalid. Enter/Correct the amount paid by Medicare as it appears on the Medicare explanation of benefits.
0181	The 1st condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
0182	Billing Provider Type and/or Specialty is not allowable for the service billed.
0185	Procedure Code billed is not appropriate for the member's gender.
0192	Prior Authorization (PA) is required for this service. An approved PA was not found matching the provider, member, and service information on the claim.
0193	The 2nd Occurrence Span code is invalid. Correct the 2nd occurrence span code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
0212	The 1st Occurrence Span Code Invalid. Correct the first occurrence span code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
0222	Claim Currently Being Processed. No Action on Your Part Required.
0240	The line was denied by Medicare. If the service is not a Medicare benefit, it can be billed as a Medicaid claim.
0248	The birth date does not match member's State ID number. Correct the birth date/State ID number. If billing for newborn care with the mother's DOB and State ID number for DAT after 11/30/2003 use modifier UK. If billing prior to 11/30/003 use modifier XN.
0250	Pap smears are limited to one per year. One routine Pap smear was paid during this 12-month period. Additional Pap smears must be billed with a diagnosis code justifying the additional tests.
0254	Accommodation Days Missing/Invalid. Please correct and resubmit.
0260	The OB services are billed incorrectly. Refer to the OB billing instructions in the Provider Manual.

EOB Code	Description
0272	The Admit Date on the claim is prior to the member's Date of Birth. Re-submit claim with an Admit Date equal to or greater than the member's Date of Birth.
0273	Claim DRG indicates newborn. Member age is greater than three years and is not considered a newborn.
0280	Only one collection fee is allowed per day. One was paid previously for this date of service.
0288	The Revenue/HCPCS Code combination is invalid.
0302	The attending provider number is not on file. Verify the 8-digit Medicaid provider number of the other provider.
0310	Counseling is not a benefit with screening. Counseling is included in the screening charge.
0352	The billing provider number is not on file.
0364	Procedure Code/Tooth Number Conflict - Tooth number on claim is not valid with the submitted procedure code. Please correct and resubmit your claim.
0381	Records indicate this tooth has previously been extracted. Correct claim or resubmit with x-ray.
0389	Header From Date of Service is required. Enter the From Date of Service.
0393	The revenue code and procedure code are in conflict. Please verify whether a HCPC can be used with this revenue code and ensure the procedure code is appropriate for the revenue code used.
0399	Date Of Service Must Fall Between The Prior Authorization Grant Date And Expiration Date.
0408	Principal Diagnosis Code is not payable for the member.
0409	No Reimbursement Rates on file for the Date(s) of Service.
0430	The lab panel is billed incorrectly. Refer to the CPT, HCPCS listing or the Provider Manual for laboratory billing instructions.
0441	5th Other Diagnosis (Institutional), 6th Diagnosis Code (Professional) is not a benefit.
0447	6th Other Diagnosis (Institutional), 7th Diagnosis Code (Professional) is not a benefit.
0451	Services with the Principal Diagnosis code are not a benefit.
0459	7th Other Diagnosis (Institutional), 8th Diagnosis Code (Professional) is not a benefit.
0461	1st Other Diagnosis (Institutional), 2nd Diagnosis Code (Professional/Dental) is not a benefit.
0471	2nd Other Diagnosis (Institutional), 3rd Diagnosis Code (Professional/Dental) is not a benefit.
0477	Services with the 8th Other Diagnosis code are not a benefit.
0481	3rd Other Diagnosis (Institutional), 4th Diagnosis Code (Professional/Dental) is not a benefit.
0491	4th Other Diagnosis (Institutional), 5th Diagnosis Code (Professional) is not a benefit.
0500	The supply procedure was billed and processed on a prior claim.
0503	Valid PA is not on file for this member and service.
0504	There is no PA on file for the procedure with the billed modifier. Check the approved PA and verify the procedure and modifier
0518	There is no valid PA on file for this item. The PA is denied, inactive, or rejected. Submit a PA for this service. When approved, enter the prior authorization number on the claim.
0522	The 3rd Other ICD Procedure is not a Covered Benefit.
0527	The 4th Other ICD Procedure is not a Covered Benefit.
0540	The service is not a benefit with an eye exam.
0550	The Principal ICD Procedure Code is not on file or invalid. Correct the procedure code.
0551	The Principal ICD Procedure is not a Covered Benefit.
0561	The 1st Other ICD Procedure is not a Covered Benefit.
0562	The 5th Other ICD Procedure is not a Covered Benefit.
0571	The 2nd Other ICD Procedure is not a Covered Benefit.
0578	Principal Diagnosis POA is missing or invalid.
0585	Family Planning Indicator is invalid.
0596	The diagnosis indicator is missing or invalid. Enter/Correct the diagnosis indicator. Refer to the Provider Manual or Help Screens for valid indicators.
0600	Claim voided or adjusted due to Recovery Audit Contractor (RAC).
0653	Claim requires manual pricing. Please attach invoice for medical services.
0665	Modifiers are required for reimbursement of these services.
0672	The date of service is out of timely filing. Refer to the School Health Services (SHS) Billing Manual.

EOB Code	Description
0675	Claims for hysterectomies must be submitted on paper. Submit a paper claim with the required attachment.
0678	Billing Provider Type and Specialty is not allowable for the Rendering Provider.
0698	Invalid claim adjustment locked for Recovery Audit Contractor (RAC).
0718	Referring Provider ID is invalid. Referring Provider ID is not required for this service.
0719	Admission Date does not match Header From Date of Service.
0720	Billing Provider contract does not have full eligibility for the date(s) of service span.
0770	The Revenue Code is not allowed for the Type of Bill indicated on the claim.
0791	Denied. This Procedure Is Denied Per Medical Consultant Review.
0801	One or more diagnosis codes are not applicable to the member's gender.
0807	DIAGNOSIS CODE INDICATED IS NOT VALID AS A PRIMARY DIAGNOSIS.
0810	A covered DRG cannot be assigned to the claim. The information on the claim is invalid or not specific enough to assign a DRG.
0824	CO1500 Employment Related Code Is Invalid. Correct code and resubmit.
0925	This procedure is limited to once per day.
0931	Condition Code is missing/invalid or incorrect for the Procedure or Revenue Code submitted.
0937	This claim is being denied because it is an exact duplicate of claim submitted.
0943	Rendering Provider is not found. Please make sure that the rendering provider has been revalidated, that the rendering provider is affiliated with your billing group and that you are using the correct rendering provider ID.
0952	Multiple Provider Locations found for Rendering Provider. Please submit NPI with taxonomy, ensure that the rendering provider is revalidated, that they are affiliated with your billing group, and that you are using the correct rendering provider ID. For questions, contact Provider Services.
0956	No billing provider location status found for date of service range. Please make sure the billing provider has been revalidated and that you are using the correct provider ID.
0966	The rendering provider is not eligible at this location on date(s) of service.
0967	Conflicting rendering provider status - in/out of state. Please make sure that the rendering provider has been revalidated, that the rendering provider is affiliated with your billing group and that you are using the correct rendering provider ID.
0968	No rendering provider location status found for date of service range. Please make sure that the rendering provider has been revalidated, that the rendering provider is affiliated with your billing group and that you are using the correct rendering provider ID.
0988	Claim Suspended. Attachment was indicated but not received. Please submit any attachments within 15 days.
0989	Claim Denied. Attachment was not received within 35 days of a claim receipt.
0996	The detail rendering provider ID is not effective for the detail dates of service on the claim. Please submit NPI with taxonomy, ensure that the rendering provider is revalidated, that they are affiliated with your billing group, and that you are using the correct rendering provider ID. For questions, contact Provider Services.
0999	The billing provider's ID is not effective for the dates of service on the claim. Please verify that the billing provider has been revalidated.
1000	Provider Submitted Reconsideration.
1005	The eligibility of the member does not fall within the department of correction restriction.
1006	The hospital classification of the billing provider does not fall within the hospital classification restriction.
1009	The maximum number of units allowed for this procedure code is 4 units per state fiscal year (July-June).
1010	This is a duplicate item that was previously processed and paid
1012	Billing provider is not eligible to bill for NHVP specific procedures
1013	New patient visit already paid to this provider - Use appropriate established patient code.
1015	CHP+ Fluoride Varnish only with Evaluation/Screening
1017	This FQHC facility is not enrolled for quality score track 2 pricing. Revenue code 520 is not payable with revenue code 529.

EOB Code	Description
1018	Member may only receive COVID-19 benefits
1022	Billing provider must use either a GO, GP or GN Procedure Code Modifier.
1023	The maximum number of units allowed for this procedure code is two per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1025	A valid enrolled ordering provider NPI is required.
1026	A valid enrolled Facility Provider NPI is required.
1027	Billing provider is not authorized to provide service from billing location.
1028	Rendering provider is not authorized to provide service from rendering location.
1029	The prescribing, referring, or ordering provider's specialty is invalid for the procedure code. The procedure is not within the scope of the provider's specialty.
1030	The place of service code is invalid for procedure code. Correct the place of service code. Refer to the Provider Manual or Help Screens for valid place of service codes.
1035	A Surgical Assistant is not allowed for this procedure.
1040	A billing provider contract could not be assigned to this claim. Please refer to the provider billing manuals for guidelines about correct billing information and that you are using the correct billing provider ID.
	Please make sure that the billing provider has been revalidated and that you are using the correct billing provider service location.
1042	Only one exam is allowed per day.
1044	Non-sterile gloves are limited to two boxes per calendar month. One unit of service is equal to one box. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1046	NPI submitted in the Billing ID field is end dated for DOS
1050	The diagnosis is invalid for the procedure. Correct the diagnosis/procedure code.
1064	The maximum number of units allowed for this procedure code is two units per state fiscal year. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1065	The maximum number of units allowed for this procedure code is one unit per state fiscal year (July - June). You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1066	The maximum number of units allowed for this procedure code is five units per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1067	The maximum number of units allowed for this procedure code is sixteen units per Fiscal Year (July - June). You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1068	The maximum number of units allowed for this code is two units within three state fiscal years (fiscal year is July - June). You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1071	Acute HH and Long Term HH services cannot be billed the same day.
1072	Acute Home Health over daily limit.
1073	Long Term Home Health over daily limit.
1081	Billing Provider Not in the system list group.
1082	Calendar year benefit has been exceeded for purchase. Item(s) are limited to $750.00 per calendar year, per member.
1083	Diapers are limited to 240 per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1084	Chux are limited to 150 per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1086	Add-on Maternity services not appropriate with primary services
1087	Quantity of one or more services billed is not allowed
1088	Single Date of Service billing requirement not met

EOB Code	Description
1089	Labor and Delivery maternity service pricing applied
1090	Antepartum maternity service pricing applied
1091	Postpartum maternity service pricing applied
1092	Multiple Babies maternity service pricing applied
1096	Claim requires invoice for specialty drug.
1100	The admitting diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
1105	The 4th Other Diagnosis code (Institutional), 5th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
1106	The 5th Other Diagnosis code (Institutional), 6th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
1107	The 6th Other Diagnosis code (Institutional), 7th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
1108	The 7th Other Diagnosis code (Institutional), 8th Diagnosis Code (Professional) is invalid for member's sex Correct the diagnosis code/sex indicator.
1109	The 8th Other Diagnosis code (Institutional), 9th Diagnosis Code (Professional) is invalid for member's sex Correct the diagnosis code/sex indicator.
1112	A National Provider Identifier (NPI) is required for the Rendering Provider listed in the header.
1117	The National Drug Code (NDC) has an age restriction.
1118	The National Drug Code (NDC) has a quantity restriction.
1120	One or more Diagnosis Codes has a gender restriction.
1122	Family Planning Funding 90%.
1123	Family Planning Funding Regular Match
1124	Family Planning Funding Error.
1127	The third modifier code is invalid for date of service. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a listing of valid modifiers.
1152	The Administrative Service and the Personal Support Service must be submitted on the same claim.
1156	Billed date is greater than batch date.
1177	Patient Location is invalid.
1178	Service is not reimbursable for Date(s) of Service.
1183	Header From Date of Service is after the Header To Date of Service. The from date of service must be before the last date of service. Correct the from date o
1188	Discharge date/destination conflict. Correct discharge date or patient status.
1195	The Procedure Code is not reimbursable for the Rendering Provider Type and/or Specialty.
1199	One or more of the NDCs submitted is not related to the procedure code billed.
1200	The pregnancy indicator is invalid for the member's age/sex. Verify the client's birth date/sex indicator.
1203	OUT OF STATE PROVIDER NOT CERTIFIED.
1204	Billing Provider is not certified for the Date(s) of Service.
1205	Out Of State Billing Provider Not Enrolled For Entire Detail DOS Span.
1208	Multiple Service Location Found For the Billing Provider NPI
1210	The Billing Provider number or the NPI are missing or in conflict. Verify the Medicaid billing provider number, the National Provider Identification (NPI), the taxonomy code, and the 9-digit zip code are entered correctly and have been registered.
1212	NDC HAS ENCOUNTER INDICATOR RESTRICTIONS
1213	The Procedure Code has Encounter Indicator restrictions.
1214	This Revenue Code has Encounter Indicator restrictions.
1215	The billed diagnosis code has encounter indicator restrictions.
1216	The billed ICD procedure code has encounter indicator restrictions.
1218	The billed procedure code has encounter indicator restrictions.
1219	The billed revenue code has encounter indicator restrictions.
1220	Modifier restriction on billed revenue code.
1221	Diagnosis Restriction on ICD Coverage Rule
1223	Billing Provider Type/Specialty not allowable for billed diagnosis.

EOB Code	Description
1234	NDC NOT COVERED.
1240	The from date of service is missing or invalid. Enter/Correct the from date of service.
1241	COVERAGE LIMITED TO PREFERRED DRUGS.
1242	COVERAGE LIMITED TO GENERIC DRUGS.
1243	COVERAGE LIMITED TO NON-INNOVATOR DRUGS.
1252	The member is not eligible to receive BCCP services after age 65.
1255	INFO only: The member is over 65 years old. Check if charges should be billed to Medicare before you bill Medicaid.
1261	Detail To Date of Service is invalid.
1273	Quantity Billed is invalid for the Revenue Code.
1275	Quantity Billed is restricted for this procedure code.
1277	MEMBER IS NOT ENROLLED FOR THE DISPENSE DATE OF SERVICE.
1278	Place of Service code is invalid.
1281	ICD Procedure Code billed is not appropriate for the member's gender.
1284	Rendering Provider is not certified for the From Date of Service.
1290	Invalid Type of Bill for this Claim Type
1291	Valid Source of Admission is required.
1292	Type of bill is not allowable for the billed diagnosis.
1299	No LTC Rate Segment found for Hospice Pricing.
1310	The members birth date is missing. Enter the members birth date.
1318	Fifth Other Surgical Code is invalid.
1319	First Other Surgical Code is invalid.
1320	Fourth Other Surgical Code is invalid.
1324	One or more Surgical Code(s) is invalid in positions six through 23.
1327	Principal Surgical Code is invalid.
1330	The total claim charge is invalid. Re-calculate and correct the total claim charge.
1331	No billing rule for revenue code.
1333	No billing rule for ICD procedure code.
1334	Header From Date of Service is invalid. Correct the From Date of Service.
1335	Header To Date of Service is invalid.
1336	Header To Date of Service is required.
1338	The net claim charge is missing or invalid. Recalculate and correct the net claim charge.
1340	Reimbursement rate is not on file for provider.
1345	Submitted referring provider NPI in the header is invalid.
1348	PROVIDER NOT ALLOWED TO BILL THIS NDC.
1353	National Drug Code (NDC) is invalid.
1354	National Drug Code (NDC) is not on file.
1355	National Drug Code (NDC) is required.
1356	NDC INVALID FOR DISPENSE DATE OF SERVICE
1357	NDC NOT COVERED FOR CLAIM TYPE.
1358	NDC RESTRICTED BY MEMBER AGE.
1362	DAW NOT ALLOWED FOR NDC.
1363	Medicare Coinsurance is greater than the annual limit. Verify and correct coinsurance amount.
1365	NDC NOT COVERED FOR DATE OF SERVICE.
1367	NDC HAS DIAGNOSIS RESTRICTIONS.
1373	No procedure billing rule for lock in plan.
1376	Submitted referring provider NPI in the detail is invalid.
1377	The Procedure Code has Diagnosis restrictions.
1378	The Revenue Code is not payable for the date of service.
1379	Billing provider contract not valid for the date of service. Please make sure that the billing provider has been revalidated and that you are using the correct provider service location. Portal: Please verify that you are logged into the correct web portal account. EDI/Paper: Please verify that you have submitted the correct billing provider service location information.

EOB Code	Description
1380	ICD Procedure Code not covered for the date of service.
1381	No billing rule for procedure.
1387	Other Coverage Indicator is invalid.
1388	The Procedure Code is not reimbursable for the Rendering Provider Type and/or Specialty.
1390	The attending physician number is missing or invalid. Enter or verify the attending physician's 10-digit NPI number.
1393	Discharge Date is before the Admission Date. The discharge date cannot be before the admission date. Correct the discharge/admission date.
1395	Admission Date is on or after Date of Receipt of Claim. The Admission Date cannot be on or after the Date of Receipt on the Claim. Correct the Admission Date
1436	Acute and Long Term Home Health Revenue Code conflict - must be billed on separate claims.
1437	Medicare non-assigned lab is not a benefit.
1445	The From Date of Service for the First Occurrence Span Code is invalid.
1446	The From Date of Service for the First Occurrence Span Code is required.
1447	The From Date of Service for the Second Occurrence Span Code is invalid.
1448	The From Date of Service for the Second Occurrence Span Code is required.
1449	The To Date of Service for the First Occurrence Span Code is invalid.
1450	The To Date of Service for the First Occurrence Span Code is required.
1451	The To Date of Service for the Second Occurrence Span Code is invalid.
1454	Procedure Code, Revenue Code, or Modifier is Invalid - Home Health
1457	Header To Date of Service is after the ICN date. The claim was received before the service was rendered. Services must be rendered before claims are submitted. Correct the date of service.
1460	There is no additional benefit for this service. Payment for this procedure was included in the payment for the surgery.
1462	The detail From Date of Service is after the detail To Date of Service. The from date of service must be before the last date of service. Correct the from date of service or the last date of service.
1463	The referring/supervising provider is not eligible on the date of service. Correct the referring/supervising provider number.
1464	Procedure Missing On Outpatient Claim - TOB 13x
1470	Denied. Invalid or missing Payer ID on claim. Claim must be resubmitted with CO_TXIX or CO_BHA in Loop 2010BB/NM109.
1472	Claim must be resubmitted with CO_TXIX in Loop 2010BB/NM109.
1473	Multiple Provider Locations Found for Billing Provider. For batch, please submit NPI with zip+4 and taxonomy. For paper and portal claims, contact Provider Services. Please make sure that the billing provider has been revalidated and that you are using the correct billing provider location.
1480	The total non-covered charges do not balance with the submitted charges. Re-calculate and enter the non-covered charges/submitted charges.
1483	This service is not a benefit of presumptive eligibility.
1503	A Rendering Provider number is required.
1504	Rendering Provider number is not found.
1507	A Rendering Provider is not required but was submitted on the claim.
1508	Multiple Provider Locations were found for Rendering Provider. Please submit NPI with taxonomy. Please make sure that the rendering provider has been revalidated, that the rendering provider is affiliated with your billing group and that you are using the correct rendering provider ID.
1512	The Procedure Code/Modifier combination is not payable for the Date of Service.
1514	The fourth modifier code is invalid for date of service. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a list
1515	The Primary Diagnosis Code is inappropriate for the Surgical Procedure Code.
1516	The Principal Diagnosis Code is inappropriate for the Revenue Code.
1517	The billed diagnos(es) are inappropriate for the procedure code.
1518	Diagnosis code is restricted by member age.
1519	The First Diagnosis Code is inappropriate for the Procedure Code.
1520	The Secondary Diagnosis Code is inappropriate for the Procedure Code.

EOB Code	Description
1522	ICD Procedure Code is not allowed on the submitted claim type.
1524	Billed amount exceeds PA amount.
1526	Services billed exceed PA amount.
1530	No billing rule for diagnosis.
1532	Claim count of Present on Admission (POA) indicators does not match count of non-admitting and non-emergency diagnosis codes.
1542	The revenue code has Family Planning restrictions.
1543	NDC HAS FAMILY PLANNING RESTRICTIONS.
1544	Procedure is not billable with member's benefit plan.
1548	Type of bill is not allowable for the billed revenue code.
1550	Transplant services not payable without a transplant acquisition revenue code.
1552	This procedure is age restricted. Member's age does not fall within the approved age range.
1553	The procedure code and modifier combination is not covered for the member's benefit plan.
1554	The claim type and diagnosis code submitted are not payable.
1558	First detail diagnosis not allowable for the billed procedure.
1560	Procedure is not covered with this billing provider location.
1561	Revenue code is not covered with this billing provider location.
1562	Revenue code is not covered with this rendering provider location.
1563	Diagnos(es) not allowable for the billed revenue code.
1564	Diagnosis is not covered with this claim region
1565	ICD procedure is not covered with this claim type.
1566	ICD procedure is not covered with this claim region.
1567	Procedure on any detail restriction on procedure coverage rule.
1568	Revenue code is not covered with this principal header diagnosis.
1569	DRG is not reimbursable with this header diagnosis.
1570	DRG is not reimbursable for this claim type.
1572	Procedure code is not reimbursable for this type of bill.
1573	Revenue code is not reimbursable for this type of bill.
1574	Procedure not covered for this claim region.
1575	Revenue code not covered for this claim region.
1577	Revenue code not covered for the member's benefit plan.
1592	Type of bill is not allowed for the billed procedure.
1598	The abortion procedure code(s) is not a benefit of the Colorado Medicaid Program. Submit a paper claim with appropriate documentation.
1599	Rendering Provider Type and/or Specialty is not allowable for the service billed.
1630	The principal ICD diagnosis code is missing. Enter the ICD diagnosis code.
1649	Revenue code requires submission of associated HCPCS code
1660	The date the plan of care was established is missing. Enter the date the plan of care was established.
1665	Unable To Process Your Adjustment Request. Member ID Not Present.
1666	Unable To Process Your Adjustment Request. Financial Payer Not Indicated.
1667	Unable To Process Your Adjustment Request. Provider ID Not Present.
1669	Unable To Process Your Adjustment Request. Original ICN Not Present.
1670	The patient status is missing or invalid. Correct the patient status code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
1671	Unable To Process Your Adjustment Request. Provider Not Found.
1672	Unable To Process Your Adjustment Request. Original Claim ICN Not Found.
1673	Unable To Process Your Adjustment Request. Claim Has Already Been Adjusted.
1674	Unable To Process Your Adjustment Request. A Different Adjustment Is Pending For This Claim.
1675	Unable To Process Your Adjustment Request. This Claim Is In Post Pay Billing For Third Party Liability Payment.
1676	Unable To Process Your Adjustment Request. Claim Can No Longer Be Adjusted. Contact Provider Services For Further Information.

EOB Code	Description
1677	Unable To Process Your Adjustment Request. The Claim Type Of The Adjustment Does Not Match The Claim Type Of The Original Claim.
1678	Unable To Process Your Adjustment Request. Member ID Number On The Claim And On The Adjustment Request Do Not Match.
1679	Unable To Process Your Adjustment Request. Provider ID Number On The Claim And On The Adjustment Request Do Not Match.
1691	This service is not payable for the same date of service as another service included on the same claim, according to the National Correct Coding Initiative.
1692	Adjustment and original claim do not have the same financial payer.
1702	The ICD surgical procedure date is not within the header dates of service. The procedure must fall within these dates. Correct the surgical procedure/header dates.
1715	The serial number does not match the PA. The serial number on the claim must match the serial number on the PA. Verify/Correct the serial number.
1720	The procedure code is missing. Enter the procedure code. Refer to the CPT or HCPCS listing for valid procedure codes.
1726	The Emergency Indicator Code is Invalid. Correct the emergency indicator.
1727	Emergency indicator restriction on billed procedure.
1728	Emergency Indicator Restriction on covered procedure.
1729	Admit Type Restriction on Covered Revenue Code.
1730	The Admission Date is after the From Date of Service. The Admission Date cannot be after the From Date. Correct the Admission/From Date
1731	Surgery Date is Before the Admission Date. The surgery date cannot be before the admission date. Correct the surgery/admission date.
1740	The number of details is not equal to the header detail count.
1786	The date of service date is out of timely filing. Refer to the new billing manual.
1788	The adjustment is outside of timely filing, and cannot reimburse at a higher rate than the original payment. The amount has been cut back to match the original claim.
1800	The tooth number is invalid/missing. Correct the tooth number.
1807	UNABLE TO PROCESS CALL PROVIDER SERVICES
1809	RENDERING PROVIDER IS NOT CERTIFIED.
1815	QMB-ONLY MEMBER RESTRICTED TO MEDICARE CROSSOVER CLAIMS.
1819	Verify billed amount and quantity billed.
1821	A covered APC/APG cannot be assigned to the claim. The information on the claim is invalid or not specific enough to assign an APC/APG.
1822	National Correct Coding Initiatives. This procedure has been approved for this date of service.
1824	HMO ID is invalid or not present on encounter claim.
1830	The units of service are missing or invalid. Enter/Correct the units of service.
1840	The submitted charge is missing. Complete the submitted charge field.
1850	The admission date is missing or invalid. Enter/Correct the admission date.
1854	1st Cycle Mass Adjustment
1860	The admission hour is missing or invalid. Enter the admission hour.
1870	The admitting diagnosis is invalid. Correct the admitting diagnosis.
1891	The Principal ICD Procedure code or date is missing or invalid. Correct the code/date.
1900	1st External Cause of Injury Code is invalid. Correct the external cause of injury code.
1901	2nd External Cause of Injury Code is invalid. Correct the external cause of injury code.
1902	3rd External Cause of Injury Code is invalid. Correct the external cause of injury code.
1903	4th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1904	5th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1905	6th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1906	7th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1907	8th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1908	9th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1909	10th External Cause of Injury Code is invalid. Correct the external cause of injury code.

EOB Code	Description
1910	11th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1911	12th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1920	The medical leave days/non-covered days are missing or invalid. Enter/Correct the number of medical leave days and/or the non-covered days.
1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.
1950	Unique Provider Service Location could not be found for Supervising NPI.
1951	Supervising NPI is inactive.
1952	No match found for Supervising NPI.
1953	Invalid Internal Supervising Provider Specified - Header.
1954	NPI is required for Supervising Provider
1955	Invalid internal supervising prov specified - Detail.
1956	Supervising Provider is not Medicaid certified
1958	Billing Provider indicated is not certified as a billing provider.
1959	Procedure not allowed to be billed with Assistant Surgeon. Please resubmit with medical necessity information.
1960	No Provider Billing Indicator Found. Please make sure the billing provider has been revalidated and that you are using the correct billing provider service location. For questions, please contact Provider Services.
1961	Billing NPI and Medicaid ID does not match.
1963	Unique Provider Service Location could not be found for Attending NPI
1964	Other 1 and Medicaid ID does not match.
1965	No match found for Other 2 NPI
1966	Unique Provider Service Location could not be found for Other 2 NPI
1967	Other 2 NPI is inactive.
1968	Other 2 NPI is required.
1969	Other 2 and Medicaid ID does not match.
1970	Unique Provider Service Location could not be found for Other 1 NPI
1971	A supervising NPI provider is required for the billed procedure. Such claims may be subject to review.
1972	Processed Per Policy Supervising NPI and Medicaid ID does not match.
1973	Attending NPI Inactive.
1974	Attending NPI and Medicaid ID does not match
1975	No Match Found for Other 1 NPI
1976	Rendering NPI Inactive
1977	Unique Provider Service Location could not be found for Other 1 NPI - Detail
1978	Unique Provider Service Location could not be found for Rendering NPI. Please submit NPI with taxonomy, ensure that the rendering provider is revalidated, that they are affiliated with your billing group, and that you are using the correct rendering provider ID. For questions, contact Provider Services.
1979	Other 1 NPI Inactive
1980	Other 1 NPI Required
1981	The Principal ICD Procedure code or date is missing or invalid. Correct the code/date.
1982	The 1st Other ICD Procedure code or date is missing or invalid. Correct the code/date.
1983	2nd Other ICD Procedure Code/Date Missing or Invalid
1984	3rd Other ICD Procedure Code/Date Missing or Invalid
1985	4th Other ICD Procedure Code/Date Missing or Invalid
1986	5th Other ICD Procedure Code/Date Missing or Invalid
1987	PRTF line item not paid on discharge date
1988	Unique Provider Service Location was not found for Other 2 NPI - Detail
1989	The PRTF claim is missing key data - Revenue code 911 or type of bill 89X
1991	PETI amount is greater than patient pay amount
1992	PETI greater than $0.00 requires occurrence span code 76
1993	Processed Per Policy PETI must be billed with accommodation revenue code

EOB Code	Description
1994	Unique Provider Service Location was not found for Referring Provider - Header. Please resubmit the claim using taxonomy and zip+4.
1995	Unique Provider Service Location was not found for Referring Provider - Detail. Please resubmit the claim using taxonomy and zip+4.
1997	The referring, ordering, prescribing or attending provider is missing or not enrolled. Please resubmit with a valid individual NPI in the attending or referring field.
2000	The type of admission is missing or invalid. Enter/Correct the type of admission. Refer to the UB04 Provider Manual or Help Screens for valid codes.
2001	Benefit is limited to one per day.
2002	Individual/Family Therapy is limited to 4 units per day.
2003	Group Therapy limited to 2 per day.
2004	Targeted Case Management (TCM) is limited to 4 units per day.
2008	Benefit is limited to 36 units per State Fiscal Year.
2009	Benefit is limited to 21 units per State Fiscal Year.
2013	Claim Processed With Closest Elig Span-Deny
2018	This procedure code is limited to 24 per date of service for School Health Service.
2021	A National Correct Coding Initiative (NCCI) procedure to procedure edit that is comprised of three scenarios: Comprehensive/Component (Column I/Column II) edits, Mutually Exclusive edits, and Action on History. These three scenarios are edits that compare procedure code pairs to identify coding logic conflicts.
2022	A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) that sets when the units of service are billed in excess of established standards for services that a member would receive on a single date of service for a given CPCS/CPT code.
2025	Behavioral health SVC not allowed for billing provider.
2026	Behavioral health SVC Revenue 900 cannot be billed with other revenue codes.
2027	Behavioral health procedure requires Revenue Code 900.
2028	Behavioral health Revenue 900 requires behavioral health procedure.
2029	The services must be billed to the member's RAE.
2030	The services must be billed to Denver Health Medicaid Choice plan.
2031	The services must be billed to Rocky Mountain Health Plan Prime.
2122	Individual/Family Therapy is Limited to 8 units per day.
2123	Group Therapy limited to 3 per day.
2124	Benefit is limited to 108 units per State Fiscal Year.
2125	Screening is limited to 52 units per State Fiscal Year.
2126	Safety is limited to 15 units per State Fiscal Year.
2220	Policy not currently enforced - Delta
2222	Policy not currently enforced.
2280	The Medicare paid date is missing or invalid. Enter the Medicare paid date from the Medicare explanation of benefits and retain the explanation of benefits.
2300	NF and LTSS overlap
2303	Hospital Readmission too close to last discharge
2305	Occupational therapy and Physical therapy services limited to a maximum of 48 units per 366 days.
2306	Occupational therapy services limited to a maximum of 5 units per date of service.
2307	Physical Therapy services are limited to a maximum of 24 units per 366 days.
2308	Physical therapy services limited to maximum of 5 units per date of service.
2309	Benefit is limited to 35 units per State Fiscal Year.
2314	Benefit is limited to 3 units per day.
2315	Benefit is limited to 3 units per State Fiscal Year
2316	Individual/Family Therapy is limited to 100 units per State Fiscal Year.
2317	Benefit is limited to 4 units per 12 months.
2326	Home Health Telehealth limited to 1 setup/lifetime.
2327	Benefit is limited to 45 units per State Fiscal Year.
2328	Screening is limited to 3 units per State Fiscal Year.

EOB Code	Description
2329	Benefit is limited to 2 units per State Fiscal Year.
2332	Benefit is limited to 16 units per day.
2333	Benefit is limited to 1 unit per day.
2334	Benefit is limited to 24 units per day.
2335	Exceeds 60-day limit for Acute Home Health.
2341	Limit 1 every 3 State Fiscal Years
2350	1 per calendar month
2351	31 per calendar month
2352	35 per calendar month
2353	50 per calendar month
2354	60 per calendar month
2355	62 per calendar month
2356	100 per calendar month
2357	120 per calendar month
2358	155 per calendar month
2359	180 per calendar month
2360	3 per calendar month
2361	4 per SFY
2362	6 per calendar month
2363	6 per SFY
2364	12 per SFY
2365	15 per calendar month
2366	20 per calendar month
2367	30 per calendar month
2368	DME Rent to Own - Purchase Price limit
2369	Benefit limited to a maximum of total days in a month.
2371	Benefit is limited to 2 units per calendar year.
2374	NHVP benefit limited to 15 units per calendar month.
2375	NHVP benefit limited to a maximum of 495 units per 33 calendar months.
2376	NHVP benefit limited to a maximum of 375 units per 25 calendar months.
2377	Initial EPSDT Screening Is Limited to one per 3 years.
2378	Exceeds Limit 1 Visit per Fiscal Year
2381	Benefit is limited to $400.00 per calendar year.
2382	Assistive Technology, Vehicle Modification, Home Accessibility Modification HCBS-SLS and HCBS-CES waiver benefit limit has been reached.
2383	Non-Medical Transportation HCBS-SLS waiver benefit limited to 16 units per month.
2384	Residential Habilitation Services and Support DIDD benefit limited to 1 unit per day.
2385	Respite Individual Day HCBS-SLS and HCBS-CES waiver benefit limited to 40 units per day.
2386	Office visits limited to 1 per day.
2387	Nursing Facility visits limited to1 per day.
2391	BH Per Diem benefit is limited to 1 per day.
2393	Prefabricated caps limited to 5 units per date of service.
2394	School Health Services limited to 6 units per day.
2396	School Health Services limited to 40 units per day.
2397	Targeted Case Mana (TCM) is limited to 240 units per State Fiscal Year.
2398	Benefit is limited to 1 unit per 12 months.
2399	Benefit is limited to 1 unit per 24 months.
2400	Benefit is limited to 1 unit per 36 months.
2401	Benefit is limited to 1 unit per 60 months.
2402	Benefit is limited to 1 per lifetime per tooth.
2403	Benefit is limited to 2 units per 12 months.
2404	Benefit is limited to 2 units per 60 months.
2405	Benefit is limited to 3 units per 60 months

EOB Code	Description
2406	Denture benefit is limited to 1 unit per 60 months.
2407	CHP+ Fluoride Varnish
2409	CHP+ PT OT ST Visit Limitations
2412	Multiple Surgeries Billed. Benefit limited to 1 unit per day.
2415	Long Term HH and Group Res Svc DIDD
2416	Respite Individual Limit SLS and CES Waivers
2418	Dental service cannot be billed with CPT history.
2419	The CPT code cannot be billed with dental service history.
2427	Bill Telehealth with Acute Home Health
2428	Bill Telehealth with Long Term Care HH Service
2430	The TCN to credit is missing or invalid. Enter/Correct the TCN of the original claim to be credited.
2449	Invalid ICD diagnosis qualifier
2450	The discharge date is before the through date. Correct the discharge/through date.
2451	The discharge hour is invalid. Please correct the discharge hour.
2452	The discharge hour is missing. Please correct the discharge hour.
2453	CHP+ SNF 30 Day Visit Limitation Per Calendar Year
2454	CHP+ Vision Exam limited to one per calendar year.
2455	CHP+ Calendar year benefit has been exceeded for purchase. Item(s) are limited to $2000.00 per calendar year, per member.
2456	CHP+ Calendar year benefit has been exceeded for purchase. Item(s) are limited to $50.00 per calendar year, per member.
2500	The members State ID number is not on file. Enter the client State ID number as it appears on the eligibility inquiry.
2520	The dates of service overlap eligibility span. Member is not eligible on each date of the span billed on the claim. Refer to the eligibility dates on the eligibility inquiry and split the claim.
2530	Possible member death. Check the eligibility inquiry.
2580	The services must be billed to the HMO/PHP/BHO listed on the eligibility inquiry.
2590	"Bill Medicare first and complete the Medicare information fields on the claim."
2640	Claim indicates TPL or TPL payment, no resource on file.
2641	Claim voided or adjusted due to Third Party Liability (TPL)
2642	Claim voided or adjusted due to Credit Balance Recovery (CBR)
2643	Claim voided or adjusted due to Program Integrity (PI)
2710	The member is ineligible on the date of service. Check the eligibility inquiry and verify the date of service.
2730	The member is in the Locked-in program. The Lock-in provider number must be either the billing, rendering, referring or supervising provider number on the claim.
2740	Claim indicates member death or discharge from NF.
2790	The claim date of service is over 4 years old. Submit the claim on paper to the fiscal agent's Medicaid Exceptions Unit with documentation supporting the processing request.
2860	The billed procedure code is not on file for this provider. The claim cannot be processed. Verify the procedure code.
2861	No Rate on File for the Date(s) of Service.
2900	Other Physician 1 must contain the Nursing Facility Provider number for payment of Hospice Room and Board services.
2941	APR-DRG HAC - The diagnosis cannot be used as a principal diagnosis.
2945	APR-DRG HAC - The discharge status is invalid. Correct the discharge status. Refer to the UB04 Provider Manual or Help Screens for valid codes.
2948	APR-DRG HAC - Invalid age in years or admission age in days
2949	APR-DRG HAC - Record does not meet criteria for any DRG
2951	APR-DRG HAC - Invalid discharge age in days.
2952	APR-DRG HAC - The principal diagnosis is invalid.
2953	APR-DRG - Invalid admitting diagnosis code.
2954	APR-DRG - Invalid principal diagnosis code.

EOB Code	Description
2955	APR-DRG - Principal diagnosis gender conflict.
2956	APR-DRG - Principal diagnosis age conflict.
2957	APR-DRG - E-code used as a principal diagnosis.
2958	APR-DRG - Non-specific principal diagnosis.
2959	APR-DRG - Manifestation used as principal diagnosis.
2960	Claim processed with closest eligibility span.
2961	APR-DRG - Unacceptable principal diagnosis
2962	APR-DRG - A secondary diagnosis is required.
2963	APR-DRG - Secondary diagnosis code is invalid
2964	APR-DRG - Secondary diagnosis gender conflict.
2965	APR-DRG - Secondary diagnosis is a duplicate of the principal diagnosis.
2966	APR-DRG - Secondary diagnosis age conflict.
2967	APR-DRG - Invalid ICD procedure code
2968	APR-DRG - ICD procedure gender conflict.
2969	APR-DRG - ICD procedure is a bilateral procedure.
2970	APR-DRG - ICD procedure is inconsistent with length of stay.
2971	APR-DRG HAC - Invalid birth weight.
2972	APR-DRG HAC - Gestational age/birth weight conflict.
2981	EAPGS-Age Conflict with Diagnosis/Procedure Code.
2985	EAPGS - Ensure if an additional modifier is necessary in order to differentiate services. Such claims may be subject to review.
2986	EAPGS - Ensure whether a modifier is necessary to differentiate same-day services. Such claims may be subject to review.
2990	This claim was processed by the Enhanced Ambulatory Patient Grouping System (EAPGS).
2991	EAPGS - Invalid or Missing Information (header)
2992	EAPGS - Invalid or Missing Information (detail)
3011	EAPGS - E-diagnosis codes are not allowed as a primary diagnosis.
3012	EAPGS - This service cannot be performed in an outpatient hospital setting
3014	EAPGS - Diagnosis is either invalid for date(s) of service or requires greater specificity.
3015	EAPGS-Reason for visit diagnosis code required for revenue code indicated.
3020	Billing Provider Type and/or Specialty is not allowable for the revenue code billed.
3029	Claim filing value is invalid.
3033	Inpatient Units/Covered/Non-Covered Days Conflict
3040	The rendering provider is not enrolled on the date(s) of service
3041	Submitting HMO is not the enrolled HMO of the Member.
3051	Rendering provider under review - suspend all claims.
3052	Attending provider under review.
3053	Prior Authorization (PA) is required for inpatient services. An approved PA was not found matching the provider, member, and service information on the claim.
3054	EVV record required and not found.
3070	Paraprofessionals require a supervising/billing provider. Complete the supervising/billing provider number field.
3090	Billing provider under review - suspend all claims
3110	The rendering provider is not a group member. Verify the rendering provider number/group number.
3120	The billing provider is not eligible at this location on date(s) of service. Please make sure that the billing provider has been revalidated and that you are using the correct provider ID/web portal account.
3130	The Principal Diagnosis code (Institutional), 1st Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.
3142	The 1st Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
3143	The 2nd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
3144	The 3rd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
3145	The 4th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.

EOB Code	Description
3146	The 5th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
3170	The first modifier code is invalid for date of service. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a listing of valid modifiers.
3171	The second modifier code is invalid for date of service. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a list of valid modifiers.
3180	The procedure code is invalid. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.
3181	The procedure code is invalid for date of service. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.
3230	The admitting diagnosis code is invalid for member's age. Correct the diagnosis code/client's birth date.
3231	The Principal Diagnosis code (Institutional), 1st Diagnosis code (Professional/Dental) is invalid for member's age. Correct the diagnosis code/ member's birth
3232	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis code (Professional/Dental) is invalid for member's age. Correct the diagnosis code/ member's birth
3233	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis code (Professional/Dental) is invalid for member's age. Correct the diagnosis code/ member's birth
3234	The 3rd Other Diagnosis code (Institutional), 4th Diagnosis code (Professional/Dental) is invalid for member's age. Correct the diagnosis code/ member's birth
3235	The 4th Other Diagnosis code (Institutional), 5th Diagnosis code (Professional) is invalid for member's age. Correct the diagnosis code/ member's birth date.
3236	The 5th Other Diagnosis (Institutional) is invalid for member's age. Correct the diagnosis code/ member's birth date.
3237	The 6th Other Diagnosis (Institutional) 7th Diagnosis Code (Professional) is invalid for member's age. Correct the diagnosis code/ member's birth date.
3238	The 7th Other Diagnosis (Institutional), 8th Diagnosis Code (Professional) is invalid for member's age. Correct the diagnosis code/ member's birth date.
3239	The 8th Other Diagnosis (Institutional), 9th Diagnosis code (Professional) is invalid for member's age. Correct the diagnosis code/member's birth date.
3241	The Principal Diagnosis code (Institutional), 1st Diagnosis Code (Professional/Dental) is invalid for member's sex. Correct the diagnosis code/sex indicator.
3242	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis Code (Professional/Dental) is invalid for member's sex. Correct the diagnosis code/sex indicator.
3243	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional/Dental) is invalid for member's sex. Correct the diagnosis code/sex indicator.
3244	The 3rd Other Diagnosis code (Institutional), 4th Diagnosis Code (Professional/Dental) is invalid for member's sex. Correct the diagnosis code/sex indicator.
3255	Inpatient lower level of care service billed with conflicting services
3261	The procedure code currently is not a benefit for date of service billed. Refer to the CPT or the HCPCS listing for valid procedure codes.
3280	The member's age is invalid for this procedure code. Verify the member's birth date/procedure code.
3290	The member's gender is invalid for this procedure code. Verify the gender/procedure code.
3291	The Principal Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.
3292	The 1st Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3294	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.
3296	The 3rd Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3298	The 4th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present

EOB Code	Description
3300	The 5th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3302	The 6th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3304	The 7th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3306	The 8th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3312	The 9th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3314	Denied. Detail Dates Are Not Within Statement Covered Period.
3318	The 10th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3324	The 11th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3330	The 12th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3336	The 13th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3342	The 14th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3348	The 15th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3354	The 16th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3360	The 17th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3361	Service billed is carved out of managed care and should be billed as FFS
3366	The 18th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3372	The 19th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.
3378	The 20th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3381	Revenue Codes 650, 651, 652, 655 and 656 may not be billed on the same day of service. See exceptions for 652 as SIA in Hospice Billing Manual on the HCPF website.
3382	The procedure and modifier combination billed for Telemedicine is not reimbursable for FQHC and RHC providers. Refer to the UB-04 Provider Manual for instructions.
3383	The NPI or MCD ID for any one of the providers (Billing, Service Facility, Rendering, Attending, Referring, Ordering or Other) is enrolled as PACE Only Subcontractor but the claim is not a PACE encounter submitted by a PACE Organization.
3384	The 21st Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.
3385	Provider license not active on date of service.
3390	The 22nd Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is presen.t
3396	The 23rd Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.
3402	The 24th Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.
3408	The Admitting Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.
3409	1st Other Diagnosis POA is missing or invalid.

EOB Code	Description
3410	2nd Other Diagnosis POA is missing or invalid.
3411	3rd Other Diagnosis POA is missing or invalid.
3412	4th Other Diagnosis POA is missing or invalid.
3413	5th Other Diagnosis POA is missing or invalid.
3414	6th Other Diagnosis POA is missing or invalid.
3415	7th Other Diagnosis POA is missing or invalid.
3416	8th Other Diagnosis POA is missing or invalid.
3417	9th Other Diagnosis POA is missing or invalid.
3418	10th Other Diagnosis POA is missing or invalid.
3419	11th Other Diagnosis POA is missing or invalid.
3420	12th Other Diagnosis POA is missing or invalid.
3421	13th Other Diagnosis POA is missing or invalid.
3422	14th Other Diagnosis POA is missing or invalid.
3423	15th Other Diagnosis POA is missing or invalid.
3424	16th Other Diagnosis POA is missing or invalid.
3425	17th Other Diagnosis POA is missing or invalid.
3426	18th Other Diagnosis POA is missing or invalid.
3427	19th Other Diagnosis POA is missing or invalid.
3428	20th Other Diagnosis POA is missing or invalid.
3429	21st Other Diagnosis POA is missing or invalid.
3430	22nd Other Diagnosis POA is missing or invalid.
3431	23rd Other Diagnosis POA is missing or invalid.
3432	24th Other Diagnosis POA is missing or invalid.
3449	The Accept Assignment indicator is Missing/Invalid or the Claim Form is invalid
3510	High variance
3520	Low variance
3530	There is no rate on file for the date of service. Charges cannot be processed.
3581	System Error - Parameter Not Found For DOS
3582	Missing Parameter Number for RVS Pricing.
3620	The Medicare deductible on the claim is greater than annual amount. The deductible amount must match the amount on the Medicare explanation of benefits. Correct the deductible amount.
3660	The service is not within the scope of the billing provider's CLIA certification. Please update the MMIS provider records with the correct CLIA number for the
3670	The primary care physician provider number is invalid/missing. Correct/Enter the primary care physician provider number.
3690	The PCP provider number is invalid for the date of service. Check the eligibility inquiry for the PCP. Contact the PCP for the provider number and enter it
3720	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.
3730	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.
3740	The 3rd Other Diagnosis code (Institutional), 4th Diagnosis Code (Professional/Dental) is invalid. Correct the diagnosis code.
3751	The revenue code is missing. Enter the revenue code. Refer to the current revenue code table for valid revenue codes.
3752	The revenue code is not on file. Refer to the current revenue code table for valid codes.
3753	The revenue code is invalid for type of bill. Correct the revenue code/type of bill. Refer to the Provider Manual or Help Screens for valid types of bill.
3756	The revenue code is not valid for this date of service. Refer to the current revenue code table for valid codes.
3780	The supervising provider number is not on file. Verify the supervising provider number.
3891	The assigned DRG is not on file.

EOB Code	Description
3930	The 4th Other Diagnosis code (Institutional), 5th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
3950	The dates of service span the end of the year. Claim must be split by year.
3960	Modifier Restriction on Reimbursement Revenue Rule
3981	RAE member restriction for procedure billing rule.
3982	RAE member restriction for revenue billing rule.
3983	The managed care plan that submitted claim is not allowed to bill procedure code.
3986	Multiple Tax-ID Found Or Does Not Have Tax-ID for the Detail From Date of Service.
4000	Member has other insurance, verify member coverage, bill carrier appropriately.
4021	This service/equipment/drug is not covered under the members current benefit plan. Please verify the members benefit plan coverage.
4040	Third Party Liability (TPL) other insurance denied.
4060	The provider's signature is missing. Complete signature field indicator, or include signature certification page for the dental or UB04 forms.
4070	The last date of service is missing or invalid. Enter/Correct the last date of service.
4081	1st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4082	2nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4083	3rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4084	4th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4085	5th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4086	6th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4087	7th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4088	8th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4091	The 1st value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4092	The 2nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4093	The 3rd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4094	The 4th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4095	The 5th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4096	The 6th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4097	The 7th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4098	The 8th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4099	The 9th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4100	The type of bill is missing or invalid. Enter/Correct the type of bill. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4101	The 10th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.

EOB Code	Description
4102	The 11th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4103	The 12th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4104	The 13th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4105	The 14th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4106	The 15th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4107	The 16th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4108	The 17th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4109	The 18th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4110	The source of admission is missing or invalid. Enter/correct the source of admission. Refer to the UB04 Provider Manual or Help Screens for valid source of admission codes.
4111	The 19th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4112	The 20th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4113	The 21st value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4114	The 22nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4115	The 23rd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4116	The 24th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4122	The 2nd condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4123	The 3rd condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4124	The 4th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4125	The 5th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4126	The 6th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4127	The 7th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4193	Billing Provider Specialty not allowed
4194	Billing Provider Type not allowed
4195	Modifier missing or invalid for service billed
4196	Place of Service not allowed for service billed
4197	Incorrect Emergency Indicator billed
4198	Detail diagnosis not allowed for procedure billed
4199	Rendering Provider Type/Specialty not allowed
4211	Modifier is invalid for procedure code.
4223	Medical Review Restriction on Procedure Code Coverage Rule.
4253	Medical Review Restriction on Revenue Code Coverage Rule.
4254	Age Restriction on Revenue Code Coverage Rule.

EOB Code	Description
4270	The programmatic leave days are exceeded. Bill excess programmatic leave days as medical leave days.
4350	The dates of service span the end of the month. Claim must be split by month.
4360	The detail date of service is missing or invalid. Enter/Correct the detail date of service. The detail dates of service must fall within the header dates of service.
4420	EAPG-Medically Unlikely Edit (MUE) units of service are billed in excess of established standards for service billed.
4422	EAPG-This service is not payable with allowed modifier for the same date of service as another service included on the same claim, according to the National Correct Coding Initiative.
4423	EAPG-Service payable when appropriate modifier is billed on the same claim for same date for National Correct Coding Initiative (NCCI).
4427	EAPG-Medical visits reported without modifier -25 or -27 on the same day as a significant procedure.
4430	EAPG-Units Billed Exceeds for Bilateral Procedure with Modifier 50
4435	EAPG-Diagnosis code is only valid for male patients
4436	EAPG-Diagnosis code is only valid for female patients
4445	EAPG-Modifier 50 should not be reported with this bilateral procedure.
4447	EAPG-Bilateral pricing Modifier 50 should not be billed more than once a claim for same procedure.
4449	EAPG-Add on Procedure Reported without Base Procedure Code.
4455	EAPG-Units of ancillary observation reported exceeds 48 hours.
4459	EAPG-The Corneal implantation service billed without a code on claim indicating acquisition of the corneal tissue.
4460	EAPG-Transfusion procedure billed without a blood product HCPCS code on the claim.
4461	EAPG-Procedure code billed indicating implantation of brachytherapy seeds or application of a radioelement but no code on claim to reflecting the item billed.
4462	EAPG-Nuclear medicine procedure code without evidence that the diagnostic or therapeutic radiopharmaceutical was billed.
4463	EAPG-Infusion therapy procedure code without evidence that substance infused was billed.
4464	EAPG-Chemotherapeutic agent or other supportive drug was provided with no evidence that the agent or drug was billed.
4465	EAPG-Service for vaccination was provided but no evidence that the vaccine administered was billed.
4466	EAPG-Injection service billed but no evidence that substance injected was billed.
4467	EAPG-Procedure code billed indicating implantation of intraocular but no evidence that the lens prothesis itself was billed.
4468	EAPG-Procedure code billed indicating implantation of a neurostimulator, but there is no evidence that the device itself was billed.
4469	EAPG-Procedure was performed for insertion of penile prothesis but there is no evidence that the prothesis itself was billed.
4470	Interim DRG bills cannot be processed.
4471	EAPG-Radiology procedure billed that includes the administration of contrast, but there is no evidence that the contrast material itself was billed.
4472	EAPG-Interventional radiology procedure billed, but there is no evidence that the surgical interventional procedure code is present on the claim.
4473	EAPG-Rendering radiology-3D procedure billed, but there is no evidence that the base radiology procedure has been reported. A 3D rendering radiology procedure may not be reported separately without a base radiology procedure.
4474	EAPG-Service for placement of needles or catheters for radioelement application. No evidence that the brachytherapy procedure for the application was billed.
4475	EAPG-Skin substitute service without evidence that the procedure for the application of the skin substitute was billed. Effective January 1, 2014, specific skin substitute products (high cost vs. low cost) must be reported with a corresponding specific high cost/lost cost skin substitute application procedure.
4480	Cutback days for DRG based on Member eligibility.

EOB Code	Description
4510	The charges are not a benefit. Client Covered by Medicare A.
4540	The client has QMB benefits only. Medicaid benefits are paid for crossover claims only.
4600	The coinsurance/deductible is billed incorrectly. The deductible/coinsurance on the claim must match the deductible/coinsurance on the Medicare explanation of benefits or the other insurance explanation of benefits.
4610	The client aid category spans Old Age Pension. Check the eligibility inquiry and split the claim.
4620	The service is not a benefit for the recipient aid category (OAP).
4700	The revenue code must be a radiology code. Refer to the current revenue code table for valid codes.
4710	The revenue code/HCPCS code combination is invalid. Refer to the UB04 Provider Manual for instructions.
4758	Billing Provider Type/Specialty Restriction on Procedure Coverage Rule.
4759	Provider Contract Restriction on Procedure Coverage Rule.
4760	The service is a Medicare benefit only.
4761	Contract Restriction on Revenue Code Coverage Rule.
4780	Revenue code restriction on billed procedure.
4840	Services for undocumented aliens are limited to emergencies. The billed service is not a benefit.
4900	The line item units of service exceed the total number of days. The line item units cannot be greater than the total number of days. Re-calculate and enter the units of service/total number of days.
4901	Billing Provider Geographic Location Restriction on Revenue Reimbursement Rule.
4902	Client Geographic Location Restriction on Revenue Reimbursement Rule.
4903	Procedure is not covered. (Does not match Procedure Group on Procedure Coverage Rule)
4920	Units of Revenue Code 655 billed exceed maximum allowed for reimbursement. Please see the Hospice Billing Manual on the HCPF website.
4930	Revenue Code 652 is not reimbursable as billed. Please see the Hospice Billing Manual on the HCPF website.
5030	The procedure code is invalid for the claim type. Correct the procedure code or bill the procedure code on the correct claim type.
5110	The prior authorization does not match the services billed on your claim. Please correct services or submit a new prior authorization for the services billed
5177	Duplicate Taxonomy Billed Within 7 Days
5260	The 5th Other Diagnosis code (Institutional), 6th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
5270	The 6th Other Diagnosis code (Institutional), 7th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
5280	The 7th Other Diagnosis code (Institutional), 8th Diagnosis Code (Professional) is invalid. Correct the diagnosis code
5290	The 8th Other Diagnosis code (Institutional), 9th Diagnosis Code (Professional) is invalid. Correct the diagnosis.
5300	The Admitting Diagnosis Code is invalid. Correct the admitting diagnosis code.
5310	The detail lines are missing or the maximum number of lines has been exceeded. Enter the detail lines. If the maximum number is exceeded, split the claim.
5320	PREVIOUS REHAB CLAIM <= 30 DAYS
5340	The principal diagnosis is invalid for DRG claims. Correct the principal diagnosis.
5527	Invalid or Missing Documentation for Non-Emergency Medical Transportation (NEMT) Service Limit.
5548	Benefit is limited to 23 units per day.
5550	Speech Rehabilitative Service Limit of 12 sessions has been met.
5551	Speech Therapy Service Limit of 12 session has been met.
5552	Speech Habilitative Service Limit of 12 sessions has been met.
5553	NEMT service limited to 4 units per date of service.
5767	This procedure is limited to 28 units per calendar year.
5768	This procedure is limited to 1120 units per calendar.
5769	This procedure is limited to 366 units per calendar year.
5812	Vision hardware service limit exceeded.

EOB Code	Description
5807	The short-term behavioral health service limit has been met, please submit the service to the Member's RAE.
5820	The number of tooth surfaces is missing or invalid for the procedure. Correct the number of tooth surfaces/procedure.
5970	The abortion ICD surgical procedure(s) is not a benefit of the Colorado Medicaid Program. Submit a paper claim with appropriate documentation.
5971	Abortion services are not a benefit of Colorado Medicaid Program. Per Department Managed Care Contract and Billing Rules, all certified documentation must be held and/or stored by the Managed Entity for auditing purposes to ensure services were provided based on the billings rules.
5990	The abortion diagnosis code(s) is not a benefit of the Colorado Medicaid Program. Submit a paper claim with appropriate documentation.
6101	Service previously paid by BHA payer.
6503	Maternity - Multiple Baby Deliveries
6505	Paid inpatient claim not found for specialty drugs.
6700	Sterilization form missing or invalid. Submit a paper claim with the completed Med-178 attached.
6990	The claim must be submitted electronically.
7200	9th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7202	10th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7204	11th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7206	12th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7208	13th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7210	14th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7212	15th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7214	16th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7216	17th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7218	18th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7220	19th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7222	20th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7224	21st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7226	22nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7228	23rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7230	24th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7232	6th Other ICD Procedure Code/Date Missing or Invalid
7233	The 6th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7234	The 6th Other ICD Procedure is not a Covered Benefit.
7235	7th Other ICD Procedure Code/Date Missing or Invalid
7236	The 7th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.

EOB Code	Description
7237	The 7th Other ICD Procedure is not a Covered Benefit.
7238	8th Other ICD Procedure Code/Date Missing or Invalid
7239	Procedure Is A Possible Duplicate.
7240	The 8th Other ICD Procedure is not a Covered Benefit.
7241	9th Other ICD Procedure Code/Date Missing or Invalid
7242	The 9th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7243	The 9th Other ICD Procedure is not a Covered Benefit.
7244	10th Other ICD Procedure Code/Date Missing or Invalid
7245	The 10th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7246	The 10th Other ICD Procedure is not a Covered Benefit.
7247	11th Other ICD Procedure Code/Date Missing or Invalid
7248	The 11th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7249	The 11th Other ICD Procedure is not a Covered Benefit.
7250	12th Other ICD Procedure Code/Date Missing or Invalid
7251	The 12th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7252	The 12th Other ICD Procedure is not a Covered Benefit.
7253	13th Other ICD Procedure Code/Date Missing or Invalid
7254	The 13th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7255	The 13th Other ICD Procedure is not a Covered Benefit.
7256	14th Other ICD Procedure Code/Date Missing or Invalid
7257	The 14th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7258	The 14th Other ICD Procedure is not a Covered Benefit.
7259	15th Other ICD Procedure Code/Date Missing or Invalid
7260	The 15th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7261	The 15th Other ICD Procedure is not a Covered Benefit.
7262	16th Other ICD Procedure Code/Date Missing or Invalid
7263	The 16th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7264	The 16th Other ICD Procedure is not a Covered Benefit.
7265	17th Other ICD Procedure Code/Date Missing or Invalid
7266	The 17th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7267	The 17th Other ICD Procedure is not a Covered Benefit.
7268	18th Other ICD Procedure Code/Date Missing or Invalid
7269	The 18th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7270	The 18th Other ICD Procedure is not a Covered Benefit.
7271	19th Other ICD Procedure Code/Date Missing or Invalid
7272	The 19th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7273	The 19th Other ICD Procedure is not a Covered Benefit.
7274	20th Other ICD Procedure Code/Date Missing or Invalid
7275	The 20th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7276	The 20th Other ICD Procedure is not a Covered Benefit.
7277	21st Other ICD Procedure Code/Date Missing or Invalid
7278	The 21st Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7279	The 21st Other ICD Procedure is not a Covered Benefit.
7280	22nd Other ICD Procedure Code/Date Missing or Invalid
7281	The 22nd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7282	The 22nd Other ICD Procedure is not a Covered Benefit.
7283	23rd Other ICD Procedure Code/Date Missing or Invalid
7284	The 23rd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7285	The 23rd Other ICD Procedure is not a Covered Benefit.
7286	24th Other ICD Procedure Code/Date Missing or Invalid
7287	The 24th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7288	The 24th Other ICD Procedure is not a Covered Benefit.

EOB Code	Description
7307	The 9th Other Diagnosis Code (Institutional), 10th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
7308	Services with the 9th Other Diagnosis code are not a benefit.
7309	The 9th Other Diagnosis (Institutional), 10th Diagnosis Code (Professional) is invalid for member's age. Correct the diagnosis code/member birth date.
7310	The 9th Other Diagnosis code (Institutional), 10th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
7313	The 10th Other Diagnosis Code (Institutional), 11th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
7314	Services with the 10th Other Diagnosis code are not a benefit.
7315	The 10th Other Diagnosis (Institutional), 11th Diagnosis Code (Professional) is invalid for member's age. Correct the diagnosis code/member's birth date.
7316	The 10th Other Diagnosis code (Institutional), 11th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
7319	The 11th Other Diagnosis Code (Institutional), 12th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
7320	Services with the 11th Other Diagnosis code are not a benefit.
7321	The 11th Other Diagnosis (Institutional), 12th Diagnosis Code (Professional) is invalid for member's age. Correct the diagnosis code/member's birth date.
7322	The 11th Other Diagnosis code (Institutional), 12th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
7325	The 12th Other Diagnosis Code (Institutional) is invalid. Correct the diagnosis code.
7326	Services with the 12th Other Diagnosis code are not a benefit.
7327	The 12th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7328	The 12th Other Diagnosis code is invalid for client's sex. Correct the diagnosis code/sex indicator.
7331	The 13th Other Diagnosis Code (Institutional) is invalid. Correct the diagnosis code.
7332	Services with the 13th Other Diagnosis code are not a benefit.
7333	The 13th Other Diagnosis is invalid for member s age. Correct the diagnosis code/ member's birth date.
7334	The 13th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7337	The 14th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7338	Services with the 14th Other Diagnosis code are not a benefit.
7339	The 14th Other Diagnosis is invalid for member's age. Correct the diagnosis code/ member's birth date.
7340	The 14th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7343	The 15th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7344	Services with the 15th Other Diagnosis code are not a benefit.
7345	The 15th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7346	The 15th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7349	The 16th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7350	Services with the 16th Other Diagnosis code are not a benefit.
7351	The 16th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7352	The 16th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7355	The 17th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7356	Services with the 17th Other Diagnosis code are not a benefit.
7357	The 17th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7358	The 17th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7361	The 18th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code

EOB Code	Description
7362	Services with the 18th Other Diagnosis code are not a benefit.
7363	The 18th Other Diagnosis is invalid for member's age. Correct the diagnosis code/ member's birth date.
7364	The 18th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7367	The 19th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7368	Services with the 19th Other Diagnosis code are not a benefit.
7369	The 19th Other Diagnosis is invalid for member's age. Correct the diagnosis code/ member's birth date.
7370	The 19th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7373	The 20th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7374	Services with the 20th Other Diagnosis code are not a benefit.
7375	The 20th Other Diagnosis is invalid for member's age. Correct the diagnosis code/ member's birth date.
7376	The 20th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7379	The 21st Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7380	Services with the 21st Other Diagnosis code are not a benefit.
7381	The 21st Other Diagnosis is invalid for member's age. Correct the diagnosis code/ member's birth date.
7382	The 21st Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7386	Services with the 22nd Other Diagnosis code are not a benefit.
7387	The 22nd Other Diagnosis is invalid for member's age. Correct the diagnosis code/ member's birth date.
7388	The 22nd Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7391	The 23rd Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7392	Services with the 23rd Other Diagnosis code are not a benefit.
7393	The 23rd Other Diagnosis is invalid for member's age. Correct the diagnosis code/ member's birth date.
7394	The 23rd Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7397	The 24th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7398	Services with the 24th Other Diagnosis code are not a benefit.
7399	The 24th Other Diagnosis is invalid for member's age. Correct the diagnosis code/ member's birth date.
7400	The 24th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7404	Services with the Admitting Diagnosis code are not a benefit.
7433	1st Patient Reason for Visit is Invalid.
7434	2nd Patient Reason for Visit is Invalid.
7435	3rd Patient Reason for Visit is Invalid.
7436	APR-DRG No Price on File
7437	APR-DRG Not Covered.
7438	Assigned APR-DRG Code Requires Manual Review - header.
7439	Assigned APR-DRG Code Age Conflict.
7440	APR-DRG Not Covered.
7441	Assigned APR-DRG Code Requires Manual Review - detail.
7442	Transfer from one Distinct Unit to another of same hospital must be billed as one continuous stay.
7443	Service must be billed as Outpatient.
7444	This abortion service is not a covered benefit.
7445	PreAdmission Testing should be billed as Outpatient.
7448	APR-DRG HAC - Gender conflict
7449	A covered DRG cannot be assigned to the claim. The information on the claim is invalid or not specific enough to assign a DRG.
7511	Billing provider has not completed revalidation.

EOB Code	Description
7512	Rendering/Performing provider has not completed revalidation.
7513	Attending provider has not completed revalidation.
7514	Ordering, Referring, and Supervising provider has not completed revalidation.
7515	Billing provider enrollment revalidation due date approaching. Revalidate now to prevent payment delays.
7516	Rendering provider enrollment revalidation due date approaching. Revalidate now to prevent payment
7517	Attending provider enrollment revalidation due date approaching. Revalidate now to prevent payment
7518	OPR (Ordering, Prescribing and Referring) provider enrollment revalidation due date approaching. Revalidate
7519	Facility provider enrollment revalidation due date approaching. Revalidate now to prevent payment delays.
7520	Facility provider has not completed revalidation.
7700	Payer not allowed for DRG or EAPG Pricing
7701	Facility provider not enrolled with payer submitted on the claim
7702	Performing or Rendering provider not enrolled with payer submitted on the claim
7703	Attending provider not enrolled with payer submitted on the claim
7704	Supervising provider not enrolled with payer submitted on the claim
7705	Referring provider not enrolled with payer submitted on the claim
7706	Ordering provider not enrolled with payer submitted on the claim
7707	Other provider not enrolled with payer submitted on the claim
7710	Member is covered by HCPF, verify member coverage, bill appropriate payer
7800	The procedure code billed on claim is missing the primary/base service procedure(s).
7801	Service is denied because it is content of service of another procedure on the current and/or previous claim.
7802	The non-payment modifier is not appropriate with the billed procedure code.
7803	Service is denied because a single procedure code exists to describe the services. Separate payment is not allowed.
7804	Separately billed services must be bundled as they are considered components of the same procedure. Separate payment is not allowed.
7805	Separately billed services must be bundled as they are considered components of the same procedure. Separate payment is not allowed.
7808	Claim line contained single/unil proc billed with qty greater than 1 on a curr or hist claim when proc code for multiple/bilateral proc is available.
7809	Only one new patient visit is allowed to the same provider group practice and specialty within three years.
7810	The procedure code billed does not represent the quantity provided when another more descriptive procedure is available.
7811	A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) sets when the units of service are billed in excess of established standards for services that a member receives on a single date of service.
7812	A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) sets when the units of service are billed in excess of established standards for services that a member receives on a single date of service.
7813	A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) sets when the units of service are billed in excess of established standards for services that a member receives on a single date of service.
7814	This service is not payable for the same date of service as another service included on the current or history claim per National Correct Coding Initiative.
7816	This service is not payable for the same date of service as another service included on the current or history claim per National Correct Coding Initiative.
7817	The payment modifier is not appropriate with the procedure code billed.
7818	Procedure is mutually exclusive or a component of a comprehensive code that is not allowed by the Integrated Outpatient Code Editor (I/OCE).
7819	No additional payment warranted for this Post-Op procedure as this service was included in the payment for the surgery.

EOB Code	Description
7820	No additional payment warranted for this Pre-Op procedure as this service was included in the payment for the surgery.
7821	No additional payment warranted for this same day service as it was included in the payment for the surgery.
7822	The Assistant-Surgeon procedure/modifier combination billed is not allowed for the procedure.
7823	The Bilateral procedure or proc/mod combination billed is not allowed.
7824	The Co-Surgeon procedure/modifier combination billed is not allowed for the procedure.
7825	Procedure code has exceeded the maximum number of times allowed for a date of service.
7826	Procedure code is not allowed to be submitted more than once per date of service.
7827	Unlisted procedure code should not be used when a more descriptive procedure code representing the service provided is available.
7894	CXT-S Claim suspended for internal review, no actions needed by the provider.
7895	CXT-S System Error - Claim suspended for internal review.
7896	CXT-S Claim suspended for internal review - Abend.
7897	CXT-S Claim suspended for internal review - TPIC.
7898	CXT-S Claim suspended for internal review - Data Validation Errors.
7899	CXT-S Claim suspended for internal review - No mapped rule found.
7900	CXT-S Claim suspended for internal review - Processing issues.
8193	This claim has been adjusted due to a change in the member’s enrollment.
9930	Pricing Adjustment - Priced per PETI Policy
9964	Manual pricing indicator, default pricing applied.
9965	No reimbursement rule, default pricing applied.
9966	No rate on file, default pricing applied.
9993	Internal-BP Processed and Denied Before Paying.
9999	Processed Per Policy .

Appendix R Revisions Log

Revision Date	Appendix	Pages	Made by
12/1/2016	Updated for new Fiscal Agent	All	HPE (now DXC)
12/27/2016	No changes required in Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx	None	HPE (now DXC)
1/10/2017	Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_3.xlsx	Multiple	HPE (now DXC)
1/19/2017	Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_4.xlsx	Multiple	HPE (now DXC)
1/26/2017	Updates based on Department 1/20/2017 approval email	Multiple	HPE (now DXC)
5/24/2017	Updates based on changes to EOB codes and descriptions	All	DXC
5/24/2017	Updates based on Fiscal Agent name change from HPE to DXC	36	DXC
6/19/2017	Updates based on changes to EOB codes and descriptions	All	DXC
9/19/2017	Updates based on changes to EOB codes and descriptions	17	DXC
11/29/2017	Updates based on changes to EOB codes and descriptions	4	DXC
1/10/2018	Updates based on changes to EOB codes and descriptions	3	DXC
4/23/2018	Updates based on changes to EOB codes and descriptions	11	DXC
6/11/2018	Updates based on changes to EOB codes and descriptions	17	DXC
7/12/2018	Updates and additions of EOB codes and descriptions based on ACC Phase II implementation	14, 15, 16, 23, 27	DXC
12/10/2018	Updates based on changes to EOB codes and descriptions	Multiple	DXC
1/17/2019	Updates based on changes to EOB codes and descriptions	10	DXC
6/12/2019	Addition of EOB codes and descriptions	20	DXC
9/13/2019	Addition of EOB codes and descriptions	1	DXC
9/16/2019	Addition of EOB codes and descriptions	2	DXC
9/27/2019	Addition of EOB codes and descriptions	1,2,17	DXC
1/29/2020	Addition of EOB codes and descriptions	13	DXC
4/6/2020	Addition of EOB codes and descriptions	5	DXC
4/29/2020	Addition of EOB codes and descriptions	22	DXC
7/15/2020	Addition of EOB codes and descriptions	21	DXC

Revision Date	Appendix	Pages	Made by
9/3/2020	Addition of EOB codes and descriptions	34, 35	DXC
9/9/2020	Addition of EOB codes and descriptions	35	DXC
9/28/2020	Addition of EOB codes and descriptions	19,27,28	DXC
11/2/2020	Addition of EOB codes and descriptions; Updated for new Fiscal Agent	23	Gainwell Technologies (formerly DXC)
11/10/2020	Addition of EOB codes and descriptions	25	Gainwell Technologies (formerly DXC)
12/8/2020	Addition of EOB codes and descriptions	13	Gainwell Technologies (formerly DXC)
1/6/2021	Addition of EOB codes and descriptions	5	Gainwell Technologies
6/14/2021	Addition of EOB codes and descriptions	18	Gainwell Technologies
10/18/2021	Addition of EOB codes and descriptions	19	Gainwell Technologies
11/30/2021	Updated the description of EOB code 2391	17	Gainwell Technologies
1/31/2022	Addition of EOB code and description.	22	Gainwell Technologies
10/5/2022	Addition of EOB code and description.	5	Gainwell Technologies
11/2/2022	Addition of EOB code and description.	22, 24	Gainwell Technologies
11/23/2022	Addition of EOB code and description.	24	Gainwell Technologies
2/8/2023	Updated description for EOB 0000.	1	Gainwell Technologies
5/12/2023	Addition of EOB code and description.	34	Gainwell Technologies
6/14/2023	Update and addition of EOB codes and descriptions	9,28,29,34	Gainwell Technologies
7/17/2023	Update and addition of EOB codes and descriptions	6, 29	Gainwell Technologies
11/9/2023	Addition of EOB codes and descriptions.	26	Gainwell Technologies
12/7/2023	Addition of EOB codes and descriptions.	14, 29	Gainwell Technologies
12/18/2023	Converted Word document to Excel	All	Gainwell Technologies
1/9/2024	Addition of EOB codes and descriptions. Rows 981 and 982.		Gainwell Technologies
1/25/2024	Addition of EOB code 5527 and description		Gainwell Technologies
2/2/2024	Correction to EOB 1997 description		Gainwell Technologies
3/29/2024	Updated description for EOB 1997.		Gainwell Technologies
4/3/2024	Addition of EOB code 0672 and description.		Gainwell Technologies
4/4/2024	Addition of EOBs 9964, 9965, 9966 and descriptions.		Gainwell Technologies
6/13/2024	Addition of EOBs 7515, 7516, 7517, 7518 and descriptions. Updated description for EOB 7520.		Gainwell Technologies
6/14/2024	Updated description for EOB 4211.		Gainwell Technologies
8/14/2024	Addition of EOBs 0600, 0698 and descriptions.		Gainwell Technologies
9/4/2024	Addition of EOB 8193 and description.		Gainwell Technologies
9/13/2024	Addition of EOB 5553 and description.		Gainwell Technologies
10/16/2024	Addition of EOB 5812 and description.		Gainwell Technologies
10/31/2024	Change to EOB 5527 description.		Gainwell Technologies
4/4/2025	Addition of EOB 5177 and description.		Gainwell Technologies

Revision Date	Appendix	Pages	Made by
4/17/2025	Additions of EOB 2641, 2642 and 2643 and descriptions. Updated description for EOB 0600.		Gainwell Technologies
5/1/2025	Additional of EOB 6505, 1096 and descriptions.		Gainwell Technologies

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page