

EOB Crosswalk Codes June 2007

VT Medicaid EOB	Adjustment Reason Code	VT Medicaid EOB Description				
136	62	PHYSICIAN'S AUTHORIZATION MUST BE WITHIN 6 MONTHS OF DATE OF SERVICE.				
1025	96	THIS SERVICE IS NOT COVERED UNDER THE LADIES FIRST PROGRAM				
1023	B5	SERVICE EXCEEDS LADIES FIRST CVD SCREENING LIMIT OF 2 PER 310 DAYS				
1030	B5	HBK AND F SERVICES EXCEED 3 ALLOWED IN 12 MONTH PERIOD WITHOUT PA				
1031	149	HBK AND F SERVICES HAVE EXCEEDED THE 3 PER LIFETIME LIMIT WITHOUT PA				
1200	125	CLAIMCHECK TEST. DISREGARD DETAIL.				
1015	96	PROGRAM COVERS COINS/DED ON DME DIABETIC SUPPLIES/J CODES SUBMITTED BY PHYSICIAN				
8000	65	DETAIL ADDED				
8001	150	DETAIL DENIED				
8002	59	AMOUNT REDUCED - MULTIPLE SURGERY PROCEDURES				
8011	59	MULTIPLE SURGERY PROCEDURES - PROCEDURE NOT REIMBURSED				
8012	59	MULTIPLE SURGERY PROCEDURES - PROCEDURE PAID AT 50 PERCENT				
8013	59	MULTIPLE SURGERY PROCEDURES - PROCEDURE PAID AT 40 PERCENT				
8014	59	MULTIPLE SURGERY PROCEDURES - PROCEDURE PAID AT 30 PERCENT				
8100	65	PROCEDURE REPLACES SUBMITTED PROCEDURE - AGE CONFLICT				
8101	65	PROCEDURE REPLACES SUBMITTED PROCEDURE - VISIT TYPE CONFLICT				
8102	65	PROCEDURE REPLACES SUBMITTED PROCEDURE - REBUNDLE CONFLICT				
8103	65	PROCEDURE REPLACES SUBMITTED PROCEDURE - GENDER CONFLICT				
8104	6	PROCEDURE REPLACED FOR AGE CONFLICT				
8105	97	PROCEDURE IS MUTUALLY EXCLUSIVE TO ANOTHER SUBMITTED PROCEDURE				
8106	57	PROCEDURE REPLACED FOR VISIT TYPE CONFLICT				
8107	97	PROCEDURE DENIED OR REPLACED - REBUNDLED INTO ANOTHER PROCEDURE				
8108	7	PROCEDURE REPLACED FOR GENDER CONFLICT				
1	B6	PROVIDER TYPE INCONSISTENT WITH CLAIM TYPE.				
2	26	BENEFICIARY INELIGIBLE FOR DATES OF SERVICE				
3	97	PAYMENT FOR SERVICE IS INCLUDED IN ENCOUNTER RATE				
4	59	PAYMENT REDUCED TO MAX.ALLOWED/MULT.SURGERY RULES; LESSER PROCEDURE ALREADY P				
5	B17	YOUR CLAIM WAS GIVEN INDIVIDUAL CONSIDERATION AND REIMBURSED ACCORDINGLY.				
6	B7	PROVIDER NUMBER HAS NOT BEEN RENEWED. CONTACT EDS ENROLLMENT FOR ASSISTANCE.				
7	128	NEWBORN CARE BILLABLE UNDER MOM'S ID FOR 7 DAYS.				
8	31	BENEFICIARY NUMBER NOT ON FILE.				
9	140	BENEFICIARY NAME/NUMBER DOES NOT MATCH OUR FILES				

10	B13	CLAIM DENIED. PAYMENT HAS ALREADY BEEN MADE ON YOUR ELECTRONIC CLAIM SUBMISSION.					
11	B7	PROVIDER NAME AND NUMBER MUST MATCH THE NAME THAT IS ON THE ENROLLMENT FORM.					
12	125	REFERRING PHYSICIAN NUMBER IS INVALID					
13	125	INDIVIDUAL CHARGES DO NOT EQUAL THE SUM OF THE DETAILS					
14	16	OTHER INSURANCE INDICATOR MISSING/INVALID. CORRECT TO 1-YES OR 2-NO AND RESUBMIT					
15	30	ALLOWED AMOUNT REDUCED BY SPENDDOWN.					
16	141	VERIFICATION OF COVERAGE INDICATES POLICY IN EFFECT FOR ALL/PORION OF DAYS.					
17	16	NET CHARGE MISSING.					
18	16	REFERRING PHYSICIAN NUMBER REQUIRED AND NOT PRESENT.					
19	140	RECIPIENT MEDICAID ID NUMBER MISSING ON AMBULANCE ATTACHMENT.					
20	40	CLAIM DENIED. DOES NOT WARRANT AMBULANCE USE.					
21	125	REFERRING PHYSICIAN CANNOT BE SAME AS ATTENDING PHYSICIAN					
22	47	PRIMARY DIAGNOSIS MISSING.					
23	16	OUTPT LAB (REV.CDE.300 OR 310) REQUIRES A LAB HCPCS CODE FROM 80002-89399 SERIES					
24	125	REFERRING PHYSICIAN NUMBER NOT ON FILE.					
25	16	ATTENDING PHYSICIAN NUMBER REQUIRED AND IT IS NOT PRESENT OR IS INVALID.					
26	16	SURGICAL DATE IS MISSING OR INVALID					
27	119	ZYBAN SMOKING CESSATION PROGRAM LIMIT OF ONE 90/DAY SUPPLY PER 365 DAYS EXCEEDED					
28	B13	NO PAYMENT IS DUE BECAUSE OTHER INSURANCE HAS PAID MORE THAN OVHA ALLOWED AMOUNT					
29	16	PRIMARY SURGICAL/PROCEDURAL DATE IS MISSING.					
30	B7	PROVIDER INACTIVE ON OR DURING DATES OF SERVICE.					
31	16	PLEASE RESUBMIT ON APPROPRIATE CLAIM FORM					
32	B6	TYPE OF BILL IS INVALID FOR THE SERVICES BILLED.					
33	B15	PAYMENT OF THIS DETAIL CONSIDERED ON FIRST LINE WITH THIS DATE OF SERVICE BILLED					
34	16	ADMISSION DATE IS MISSING.					
35	16	THE ADMISSION DATE IS LATER THAN THE FROM AND/OR THRU DATE OF SERVICE.					
36	125	INAPPROPRIATE CODE. REFER TO YOUR CURRENT DENTAL LIST.					
37	50	ADMISSION CODE DOES NOT WARRANT EMERGENCY ROOM/ SERVICES/SITUATION.					
38	29	CLAIM PAST TWO YEARS - CONTACT OVHA FOR CONSIDERATION OF TIMELY FILING.					
39	119	DIABETIC COUNSELING G0108 IS LIMITED TO 12 SESSIONS PER CALENDAR YEAR					
40	17	THE INFORMATION ON THE ATTACHMENT IS NOT VALID.					
41	16	FROM DATE OF SERVICE IS MISSING.					
42	16	PATIENT STATUS CODE IS MISSING.					
43	16	ADMISSION CODE IS MISSING.					
44	16	FROM DATE OF SERVICE IS INVALID.					
45	16	THE DISCHARGE DATE OF SERVICE IS MISSING/INVALID					
46	16	THE THRU DATE OF SERVICE IS MISSING					

47	16	NDC IS MISSING, PLEASE SUBMIT A CORRECTED FORM.					
48	125	INAPPROPRIATE PROCEDURE CODE. PLEASE REFER TO YOUR CURRENT CPT MANUAL					
49	B5	OADAP RESIDENTIAL INTENSIVE TREATMENT LIMITED TO 30 DAYS PER CALENDAR YEAR					
50	125	INAPPROPRIATE BILLING OF MULTIPLE PROCEDURE OR HCPCS OR REVENUE CODES.					
51	B18	CODE/SERVICE OR CODE/MODIFIER COMBINATION NOT VALID FOR DATE OF SERVICE BILLED					
52	96	THIS SERVICE IS NOT COVERED FOR NON-MEDICAID BENEFICIARIES - MH, PQ, PS					
53	125	DATE OF SERVICE REQUIRED FOR EACH LINE BILLED					
54	125	THIS CODE HAS BEEN DELETED BY HCPCS. REFER TO MEDICARE UPDATES.					
55	125	THE THRU DATE OF SERVICE IS BEFORE THE FROM DATE OF SERVICE.					
56	16	DOCUMENTATION NEEDED SUBSTANTIATING NUMBER OF UNITS BILLED.					
57	125	BILL CODE ONCE ONLY WITH TOTAL NUMBER OF UNITS. INCLUDE OP NOTES AND/OR EXPLAIN.					
58	16	QUANTITY OR UNITS MISSING					
59	16	NOTICE OF DECISION ATTACHMENT MISSING					
60	16	DETAIL CHARGE IS MISSING					
61	42	NO PAYMENT DUE. SPENDDOWN GREATER OR EQUAL TO ALLOWED AMOUNT.					
62	125	INCORRECT BILLING OF SPENDDOWN ACCORDING TO INSTRUCTIONS					
63	62	THIS SERVICE REQUIRES PRIOR AUTHORIZATION					
64	125	REVENUE CODE DOES NOT MATCH DESCRIPTION PROVIDED. PLEASE CORRECT AND RESUBMIT.					
65	16	THE PLACE OF SERVICE CODE IS MISSING					
66	125	SERVICE OVERLAPS GENERAL ASSISTANCE AND MEDICAID PROGRAMS. EDS WILL RESUBMIT					
67	16	PROCEDURE CODE MISSING					
68	125	NDC NOT ON FILE					
69	125	NDC/PROCEDURE DOES NOT MATCH DESCRIPTION PROVIDED. PLEASE CORRECT AND RESUBMIT					
70	96	NON-COVERED SERVICE FOR PROVIDER AS BENEFICIARY NOT IN PCP PROGRAM.					
71	16	PRESCRIBING PHYSICIAN NUMBER MISSING					
72	125	DISPENSING DATE MISSING/INVALID.					
73	16	ESTIMATED DAYS SUPPLY MISSING					
74	97	SERVICE INCLUDED IN OFFICE/MEDICAL VISIT.					
75	42	ADA MEMBERSHIP FEE (PROCEDURE CODE W8001) LTD.TO ONCE PER RECIPIENT LIFETIME.					
76	119	CLAIM/DETAIL DENIED. DME PURCHASE HAS BEEN REACHED.					
77	16	REFILL INDICATOR IS MISSING OR INVALID					
78	143	ADJUSTMENT RESULTED IN REDUCED PAYMENT. ACCOUNTS RECEIVABLE SET UP FOR RESIDUAL					
79	47	VT MEDICAID HAS A UNIQUE PROCEDURE CODE FOR THIS SERVICE.					
80	17	MEDICAL NECESSITY FORM INCOMPLETE. PLEASE COMPLETE AND RESUBMIT.					
81	16	SIGNATURE ON MNF NOT WITHIN 6 MONTHS (ONE YR FOR OSTOMY/UROLOGIC) OF BILLED DOS					
82	63	THIS PAYMENT IS THE RESULT OF AN ADJUSTMENT REQUEST					
83	63	THIS RECOUPMENT IS THE RESULT OF AN ADJUSTMENT REQUEST.					

84	88	THIS AMOUNT WITHHELD AS A RESULT OF AN OUTSTANDING RECEIVABLE				
85	63	THIS CREDIT TRANSACTION IS THE RESULT OF YOUR REFUND REQUEST.				
86	B13	DETAIL DENIED: CONSIDERED INCLUDED IN A PREVIOUSLY BILLED SERVICE				
87	63	THIS CREDIT TRANSACTION IS THE RESULT OF AN EDS CHECK ISSUED TO YOU IN ERROR.				
88	97	ANOTHER PAID SERVICE/CODE IS INCLUDED IN THIS ONE. RECOUP IT BEFORE REBILLING.				
89	16	BRAND CERTIFICATION INDICATOR MISSING				
90	96	CLAIM/DETAIL DENIED. NO PAYMENT DUE WHEN RECIPIENT PAYS CHARGE.				
91	96	SERVICE DENIED; NOT COVERED BY VERMONT MEDICAID PROGRAM				
92	3	PAYMENT REDUCED DUE TO PRENATAL AND CHILDREN'S HEALTH CARE PROGRAM CO-PAY.				
93	42	PAYMENT REDUCED TO MAXIMUM ALLOWABLE AMOUNT.				
94	97	A PORTION OR ALL OF THESE DAYS WERE PAID AS AN INPATIENT CLAIM.				
95	22	CLAIM CUTBACK DUE TO OTHER INSURANCE PAYMENT				
96	18	CLAIM DENIED. EXACT DUPLICATE OF SERVICE PREVIOUSLY PAID.				
97	97	REIMBURSEMENT FOR ANCILLARY CHARGES INCLUDED IN PER DIEM RATE				
98	88	THIS AMOUNT HAS BEEN APPLIED TO AN OUTSTANDING ACCOUNTS RECEIVABLE.				
99	142	PAYMENT REDUCED BY APPLIED INCOME/PATIENT SHARE AMOUNT				
100	17	YOUR RESUBMITTED CLAIM'S R.A. DATE IS ILLEGIBLE.				
101	16	PROVIDER NAME MISSING.				
102	17	CLAIM IS ILLEGIBLE. PLEASE RESUBMIT A LEGIBLE FORM.				
103	17	CLAIM (DETAIL) DENIED. ATTACHMENT DOES NOT MATCH THE CLAIM				
104	23	CLAIM DENIED. NO COINSURANCE OR DEDUCTIBLE DUE.				
105	17	INITIAL EOB IS NEEDED IN ADDITION TO THE ADJUSTMENT EOB TO PROCESS CLAIM.				
106	96	SERVICE NOT COVERED FOR VHAP BENEFICIARY				
107	16	CLAIM/DETAIL SUBMITTED WITHOUT ANY SERVICES BILLED.				
108	16	REVENUE CODE IS MISSING.				
109	128	NEWBORN CARE BILLABLE UNDER MOM'S ID UNTIL MOM IS DISCHARGED.				
110	17	MEDICARE BENEFITS SHEET ILLEGIBLE. PLEASE RESUBMIT WITH LEGIBLE COPY				
111	141	DEDUCTIBLE NON-COVERED. RECIPIENT IS INELIGIBLE ON THE FIRST DATE OF SERVICE.				
112	B7	OUR RECORDS SHOW ATTENDING PHYSICIAN INELIGIBLE ON OR DURING DATE(S) OF SERVICE.				
113	57	MEDICARE BENEFITS SHEET DOES NOT MATCH CLAIM				
114	125	ATTENDING PROVIDER NUMBER IS INVALID.				
115	125	MEDICARE PAID DATE MISSING OR ILLEGIBLE.				
116	42	NO CROSS-OVER PAYMENT DUE. OTHER PAYMENT GREATER OR EQUAL TO ALLOWED AMOUNT.				
117	125	ATTENDING/PRESCRIBING PROVIDER NUMBER NOT ON FILE.				
118	125	THIS SURGICAL PROCEDURE CODE IS NOT A VALID ICD-9 PROCEDURE CODE.				
119	8	EXPLAIN USE OF ICD-9 PROCEDURE CODES 87-9999 WITH SURGERY-RELATED REVENUE CODE				
120	16	PSRO INDICATOR MUST BE A C1 OR C5				

121	39	REQUESTED PRIOR AUTHORIZATION HAS BEEN DENIED. NOTE STATUS ON RETURNED PA FORM.				
122	62	THIS PRIOR AUTHORIZATION HAS ALREADY BEEN EXHAUSTED				
123	125	ACCIDENT/OCCURENCE/EMPLOYMENT INDICATOR MISSING.				
124	125	ELECTRONIC ADJUSTMENT CAN NOT BE PROCESSED AT THIS TIME. PLEASE RESUBMIT AFTER 8/				
125	16	ACCIDENT/OCCURENCE DATE MISSING				
126	16	PRIOR AUTHORIZATION FROM VDOH IS REQUIRED FOR MORE THAN 20 "AT RISK" VISITS/YEAR				
127	16	YOUR RESUBMITTED CLAIMS RA DATE IS MISSING				
128	17	COMPOUND DRUG ATTACHMENT IS ILLEGIBLE. RESUBMIT CLAIM WITH LEGIBLE ATTACHMENT.				
129	15	THIS PROCEDURE CODE/SERVICE DOES NOT MATCH THE PROCEDURE CODE/SERVICE AUTHORIZ				
130	57	CAST REMOVAL CODES CAN BE BILLED ONLY FOR CASTS APPLIED BY ANOTHER MD/MD GROUP				
131	B13	DETAIL DENIED. CAST APPLICATION INCLUDED IN INITIAL CARE.				
132	17	DRUG PREGNANCY INDICATOR INVALID				
133	5	PHYSICIAN CANNOT BILL CAST MATERIALS IN A NON-OFFICE SETTING.				
134	B13	SERVICES PRIOR TO JULY 1 WERE REIMBURSED BY CAPITATION PAYMENT.				
135	42	PAYMENT DENIED: LOADING FEE CAP HAS BEEN REACHED.				
294	A1	YEARLY TREATMENT PLAN (Y0069)CANNOT BE BILLED BY NON-LOCKIN PCP PROVIDER				
137	15	THE CERTIFICATE NUMBER ON THE ATTACHMENT DOES NOT MATCH THE ONE ON OUR FILE.				
138	17	RECIPIENT NAME, D.O.S., PROVIDER SIGNATURE AND CHARGES REQUIRED ON ATTACHMENT.				
139	16	AMOUNT OF SPENDDOWN SHOULD BE ENTERED IN PRIOR PAYMENT FIELD ON UB92 CLAIMS				
140	125	ONLY REVENUE CODES 300 OR 310 ARE ALLOWED ON OUTPATIENT CLAIMS WHEN BILLING LAB.				
141	125	THESE SERVICES REQUIRE HCPCS/CPT CODES				
142	125	INVALID REVENUE CODE FOR SERVICES RENDERED. REFER TO YOUR LIST OF CODES.				
143	B13	REIMBURSEMENT FOR ANCILLARY CHARGES INCLUDED IN %/PER DIEM RATE FOR BIRTH ROOM				
144	B5	TIME/UNITS EXCEED(S) THE NORM.PLEASE RESUBMIT WITH EXPLANATION OR DOCUMENTATION				
145	17	NON-INJECTED MEDS ADMINISTERED IN THE OFFICE REQUIRE OFFICE NOTES AND INVOICE				
146	3	CLAIM PAYMENT AMOUNT REDUCED BY REQUIRED CO-PAY.				
147	62	PAYMENT DENIED: REQUIRED AUTHORIZATION WAS NOT OBTAINED IN ADVANCE OF SERVICE.				
148	17	PROFESSIONAL REVIEW ORGANIZATION (PRO) CERTIFICATION FORM IS INCOMPLETE.				
149	24	THIS IS THE PMPM PAYMENT FOR YOUR PARTICIPATION IN VERMONT PRIMARY CARE PLUS				
150	16	EFFECTIVE DATE IS MISSING.				
151	8	THERAPEUTIC (COURT-ORDERED) ABORTION MUST BILL CODE W4888 (TOTAL ABORTION CARE)				
152	133	THIS ABORTION-RELATED SERVICE HAS BEEN FORWARDED TO ADMIN SERVICES FOR PAYMENT				
153	8	REBILL ABORTION RELATED SERVICES SEPARATELY.				
154	17	ABORTION CERTIFICATION FORM REQUIRED FOR PAYMENT				
155	40	NON-URGENT SERVICE. RECIPIENT SHOULD BE REFERRED TO IN-STATE FACILITY.				
156	125	EFFECTIVE DATE IS INVALID.				
157	97	OBSERVATION ROOM SVCS PAID AT PER/DIEM OR PERCENTAGE RATES INCLUDE ANCILLARIES				

158	42	APPROVAL IS FOR INPATIENT. PAYMENT REDUCED TO PER DIEM RATE.			
159	16	CPT CODE ALLOWED ONLY IN FIELD 81A & ONLY WHEN ICD-9 SURGICAL CODE IN FIELD 80			
160	17	THIS MANUFACTURER'S NUMBER IS OBSOLETE. REBILL, USING NEW NUMBER.			
161	35	DRUG REFILLS LIMITED TO 5 PER PRESCRIPTION			
162	125	LCSW/LCMHC/LMFC PROVIDERS CAN ONLY BILL APPROVED PROCEDURE CODES.			
163	16	TOOTH NUMBER IS MISSING			
164	125	EPSDT MODIFIERS ARE VALID ONLY IN PAIRS (FOR EXAMPLE: ABAP, NMCI, NMNA, ETC...)			
165	16	THE TOOTH SURFACE CODE IS MISSING			
166	B7	PROVIDER NOT ELIGIBLE FOR ALL OR A PORTION OF DAYS BILLED.			
167	97	REIMBURSEMENT FOR THIS SERVICE IS CONSIDERED AS PART OF YOUR PER DIEM.RATE.			
168	16	EPSDT/FAMILY PLANNING INDICATOR MISSING			
169	125	PRESCRIPTION NUMBER MISSING/INVALID			
170	16	INAPPROPRIATE/INVALID MANUFACTURER NUMBER. REBILL, USING CORRECT NUMBER.			
171	8	HOSPITAL BILLS FOR PROCEDURE 863 REQUIRE THE MD'S CPT CODE IN BOX 81A			
172	B5	HEARING AIDS & DISPENSING FEES LTD TO 1/EAR/3YRS. MORE NEED PA FROM THE OVHA.			
173	50	DETERMINED NOT MEDICALLY NECESSARY.			
174	35	CLAIM DENIED. YOUR 2 MONTH SUPPLY OF NICORETTE HAS BEEN MET.			
175	62	PRIOR AUTHORIZATION DATES ARE NOT ADEQUATE FOR ALL SERVICES BILLED			
176	18	THIS SERVICE IS AN EXACT DUPLICATE PER NDC NUMBER AND REFILL NUMBER.			
177	125	MAINTENANCE DRUGS FOR A VSCRIPT BENEFICIARY REQUIRE A 90 DAY SUPPLY			
178	4	CODE 11975ZMI IS NORPLANT IMPLANTATION; 11976ZMR IS NORPLANT REMOVAL			
179	35	SMOKING CESSATION PROGRAM IS LIMITED TO SIX MONTHS FROM ORIGINAL START DATE			
180	125	TOTAL DAYS BILLED ARE NOT EQUAL TO TOTAL ELAPSED DAYS			
181	62	SERVICE DENIED. OVHA/PRO REVIEW INDICATES PRECERTIFICATION NOT MET.			
182	16	PLEASE RESUBMIT WITH CLARIFICATION THAT SECONDARY CODE IS EITHER ICD-9 OR CPT.			
183	125	OUTPATIENT RADIOLOGY REVENUE CODES REQUIRE HCPCS CODE (70000 SERIES OR G-CODE)			
184	B7	PROVIDER NUMBER NOT CERTIFIED FOR THIS TIME PERIOD			
185	62	CLAIM DENIED. SSI RECIPIENT. SERVICE REQUIRES PRIOR AUTHORIZATION FROM KAISER			
186	125	ICD-9 SURGICAL PROC.CODE REQUIRED WHEN BILL REV.CODE 360, 361, 362, 367, OR 490.			
187	A1	DDMHS/ADAP CASE MGMT & REHAB SERVICE NOT COVERED UNDER THIS PROVIDER NUMBER			
188	125	BILLED/SURGICAL DATE OF SERVICE IS INVALID AND/OR DOES NOT MATCH NOTES			
189	35	90846 IS LIMITED TO 3 SESSIONS PER RECIPIENT LIFETIME. OVHA AUTH. REQUIRED FOR MORE			
190	125	REFERRED TO PHYS MISSING/INVALID/NOT ON FILE/NOT ELIGIBLE ON DOS			
191	97	PAYMENT FOR W4888 INCLUDES ALL RELATED SERVICES.			
192	B19	OTHER INSURANCE ATTACHMENT/MEDICARE EOMB REVIEWED AND DENIED BY OVHA.			
193	B19	OTHER INSURANCE HAS BEEN CONSIDERED			
194	100	PAYMENT HAS BEEN RECEIVED BY BENEFICIARY FOR THIS SERVICE			

195	99	CLAIM CUTBACK DUE TO MEDICARE PAYMENT					
196	16	NDC IS OBSOLETE					
197	96	YEARLY TREATMENT PLAN (Y0069) NON-COVERED FOR BENEFICIARY - NOT ENROLLED IN PCP					
198	96	DESI DRUG NOT COVERED					
199	97	PAYMENT DENIED. SECONDARY SURGERY INCIDENTAL TO PRIMARY SURGERY					
200	96	DIET PRODUCTS NOT COVERED					
201	A1	MANUFACTURER HAS NOT SIGNED REBATE AGREEMENT.					
202	16	MEDICARE PAID AMOUNT ON EOMB IS MISSING OR ILLEGIBLE.					
203	16	FUNDING SOURCE/ELIGIBILITY OVERLAP. RESUBMIT AS SEPARATE CLAIMS PER SERVICE					
204	16	FUNDING SOURCE/ELIGIBILITY OVERLAP. RESUBMIT AS SEPARATE CLAIMS PER SERVICE					
205	125	BILL SAME REVENUE CODE ONLY ONCE, PER DATE OF SERVICE.					
206	A1	PRODUCT HAS BEEN REMOVED FROM THE MARKET					
207	A1	NATIONAL DRUG CODE NOT COVERED WHEN RECIPIENT IS IN A NURSING HOME					
208	17	ADAP "AUTHORIZATION FOR TREATMENT EXTENSION" MISSING FOR THESE DATES OF SERVICE.					
209	35	OADAP PRIMARY RESIDENTIAL INTENSIVE TREATMENT IS LIMITED TO 21 DAYS PER EPISODE					
210	16	WHEN BILLING FOR NONCONSECUTIVE DAYS, BILL SEPARATE ENCOUNTER CODES					
211	125	WHEN BILLING FOR NONCONSECUTIVE DAYS, PLEASE BILL EACH DATE SEPARATELY.					
212	A1	SERVICE NON-COVERED WHEN BILLED BY LICENSED OCCUPATIONAL THERAPIST.					
213	96	SERVICE NON-COVERED WHEN BILLED BY LICENSED PHYSICAL THERAPIST.					
214	17	RECIPIENT DATE OF BIRTH IS MISSING					
215	96	THIS SERVICE IS NOT COVERED FOR CRT CLIENT.					
216	16	RECIPIENT DATE OF BIRTH DOES NOT MATCH OUR FILES					
217	42	CLAIM CORRECTION FORM NOT RECEIVED WITHIN THE 45 DAY LIMIT.					
218	35	ADAP INTENSIVE OUTPATIENT TREATMENT (X9007) IS LIMITED TO 30 DAYS PER CAL.YEAR.					
219	35	OADAP ADOLESCENT RESIDENTIAL TX (X9005) LIMITED TO 120 DAYS PER YEAR					
220	35	ELECTRONIC ADJUSTMENT ACCEPTED SEE NEW ICN					
221	17	INVOICE MUST CLARIFY WHICH ITEM IS BEING BILLED AND ITS UNIT COST.					
222	A1	THIS CLAIM HAS BEEN DENIED DUE TO A POS REVERSAL TRANSACTION					
223	16	URGENT/ELECTIVE ADMISSIONS REQUIRE NOTIFICATION FOR PCPLUS BENEFICIARIES					
224	16	MD'S CODE FOR ORTHOTICS & SUPPLIES IS 99070 WITH COMPLETE DESCRIPTION & INVOICE					
225	A1	CMHC'S NOT ALLOWED TO BILL VHAP LTD/VHAP MC BENEFICIARIES UNDER THIS NUMBER.					
226	A1	S9480 DAY HOSPITAL SERVICES (PARTIAL HOSP) COVERS ONLY VHAP MC BENEFICIARIES					
227	52	ATTENDING PHYS NOT ELIGIBLE MEMBER OF BILLING GROUP FOR ALL/PART D.O.S. BILLED					
228	16	PROOF THAT LIFETIME RESERVE DAYS WERE USED MUST BE INDICATED.					
229	35	PCP ATTENDING PREVIOUSLY BILLED FOR Y0069 WITHIN 365 DAYS					
230	16	NO DENIAL CODE ON ATTACHED MEDICARE EOMB					
231	57	DME NOT COVERED WHEN BILLED PLACE OF SERVICE INPATIENT/OUTPATIENT					

232	58	PHYSICAL THERAPY/CHIROPRACTIC SERVICES NOT COVERED WHEN POS INPATIENT/OUTPATIENT				
233	89	TOTAL COMPONENT AND TECHNICAL OR PROFESSIONAL COMPONENTS CANNOT BOTH BE PAID				
234	58	SUPPLIES AND MATERIALS NOT COVERED FOR PHYSICIAN WHEN POS INPATIENT/OUTPATIENT				
235	4	PHYSICIAN MUST BILL MODIFIER 26 (PROF COMPONENT) WHEN POS INPATIENT/OUTPATIENT				
236	58	ONLY SPEC 22 OR 7 PAID FOR CYTOLOGY/PATHOLOGY WHEN POS INPATIENT/OUTPATIENT				
237	4	EPSDT MODIFIER REQUIRED FOR THIS SERVICE				
238	133	A POST-TREATMENT RADIOGRAPH+THE COMPLETED CLAIM MUST BE SENT TO DDH FOR REVIEW				
239	35	SMOKING CESSATION PRODUCTS LIMITED TO TWO SCRIPTS/REGIMENS PER CALENDAR YEAR				
240	A1	VERMONT MEDICAID COVERS DME FOR IN-HOME USE ONLY				
241	A1	DME SUPPLIER REQUIRED TO HAVE MNF ON FILE				
242	17	PLEASE CLARIFY INVOICE TO EXPLAIN BILLED AMOUNT.				
243	17	MEDICARE PAID DATE IS ILLEGIBLE.				
244	47	PRIMARY DIAGNOSIS INVALID. VERIFY IN CURRENT ICD-9 CM MANUAL				
245	17	AMBULANCE CERTIFICATION FORM MUST STATE ORIGIN AND DESTINATION OF AMBULANCE.				
246	17	AMB.CERT. MUST STATE TYPE OF HOSPITAL ADMISSION (ER OUTPT, INPT ADMIT, OR OTHER)				
247	16	CLAIM DOES NOT INDICATE BILLED AMOUNT REDUCED BY SPENDDOWN PER INSTRUCTIONS				
248	6	VHAP MANAGED CARE PROGRAM COVERS ADULT DENTAL SERVICES ONLY UNTIL 11/30/2001				
249	52	REFERRING PHYSICIAN NUMBER IS NOT ELIGIBLE.				
250	125	ADMISSION CODE IS NOT A VALID VALUE.				
251	125	REVENUE CODE IS INVALID				
252	125	QUANTITY OR UNITS NOT VALID FOR SERVICE BILLED.				
253	35	SMOKING CESSATION PRODUCT LIMITED TO 180 DAYS PER CALENDAR YEAR				
254	125	DETAIL DOS NOT WITHIN HEADER FROM DOS TO THRU DOS				
255	A1	VSCRIPT/VPHARM COVERS MAINTENANCE DRUGS ONLY				
256	17	RESUBMIT FOR BILLING OF NON COVERED SERVICES ONLY.				
257	17	DATE(S) ON THE ATTACHMENT DO(ES) NOT MATCH SERVICE DATE(S) ON THE CLAIM				
258	B13	HOME HEALTH AGENCY HAS BEEN PAID FOR INSTITUTIONAL RESPITE CARE SERVICE.				
259	63	DISREGARD THIS DETAIL. PROCESSING ERROR.				
260	A1	RECIPIENT ENROLLED IN SPECIALTY FUNDED PROGRAM WHICH DOES NOT COVER THIS SERVICE				
261	35	VDH FAMILY SUPPORT WORKER SERVICES (W0083) ARE LIMITED TO A MAXIMUM OF 20 VISITS				
262	17	PLEASE ATTACH OTHER INSURANCE DENIAL PRINT OUT, NOT VT MEDICAID DENIAL.				
263	16	FEDERAL STERILIZATION CONSENT FORM REQUIRED.				
264	6	BRATTLEBORO RETREAT PROV # RESTRICTED TO PCPLUS INPATIENT- VHAP 18+/MEDICAID 22+				
265	17	REHAB THERAPY START DATE IS INVALID				
266	62	THE BILLED DATE(S) OF SERVICE IS(ARE) NOT COVERED BY THE GIVEN PA.				
267	30	SPECIALY FUNDED RECIPIENT NOT ELIGIBLE FOR MEDICAID				
268	125	APPROPRIATE PROCEDURE CODE FOR HMO CO-PAY IS T1015 AS OF 02/01/04.				

269	125	THERAPY PROCEDURE CODE IS 9389					
270	16	PRIMARY SURGICAL DATE IS INVALID.					
271	125	THE THRU DATE OF SERVICE IS INVALID					
272	141	THIS CLAIM HAS BEEN PRO-RATED -RECIPIENT WAS NOT ELIGIBLE FOR ALL DAYS BILLED					
273	8	ICD-9 SURGICAL PROC.CODE REQUIRED FOR EACH SURGERY DONE. (Y570 IS NOT SURGERY)					
274	16	ESTIMATED DAYS SUPPLY NOT A VALID VALUE					
275	18	HISTORY INDICATES POSSIBLE DUPLICATE. IF NOT, RESUBMIT WITH SUPPORTING DOCUMENT.					
276	125	RESUBMIT WITH HOSPITAL RECORDS SHOWING DATE & HOUR OF ARRIVAL & OF DISCHARGE					
277	A1	THIS CLAIM WAS A PRIOR AUTHORIZATION REQUEST. CLAIM DENIED & SENT TO PA UNIT.					
278	125	PROCEDURE/REVENUE CODE NOT ACCEPTED BY VT HEALTH ACCESS &/OR DOES NOT EXIST.					
279	47	NON-COVERED SERVICE.MEDICAID FOLLOWS THE SAME RULES AS YOUR COMMERCIAL INSURANCE					
280	8	CPT AND ICD-9 CODES MUST INDICATE/REFLECT SAME SURGICAL PROCEDURE					
281	125	CHARGES ON INSURANCE/MEDICARE ATTACHMENT DO NOT MATCH CHARGES ON CLAIM.					
282	62	PRIOR AUTHORIZATION HAS NOT BEEN APPROVED FOR DATE(S) OF SERVICE.					
283	62	AIR AMBULANCE REQUIRES PA & NEEDS TO BE BILLED ON A HCFA USING PROC CODE A0040					
284	52	PRESCRIBING PHYSICIAN NUMBER NOT ELIGIBLE ON DOS					
285	16	PHARM.MANAG'MT (90862) CAN'T BE PD SAME DOS AS PSYCHOTX (90804-90844 & 90855).					
286	16	SECONDARY DIAGNOSIS CODE IS NOT CONSISTENT WITH THE AGE OF THE RECIPIENT					
287	16	PRESCRIBING PHYSICIAN MUST BE AN INDIVIDUAL,NOT A GROUP NUMBER.					
288	125	PRESCRIBING PHYSICIAN NUMBER IS NOT ON FILE.					
289	35	MR GROUP THERAPY IS LIMITED TO 40 UNITS (10 HOURS) PER WEEK.					
290	8	CPT CODE ON UB RESTRICTED TO FIELD 81 & ONLY WHEN PA NEEDED FROM CONTRACTED PRO					
291	35	DMH GROUP THERAPY LIMITED TO 2 HOURS (8 UNITS) PER DAY					
292	16	BILLED AMT APPEARS INCORRECT COMPARED TO ALLOWED AMT. PLEASE VERIFY AND RESUBMIT					
293	136	MEDICAID PAID DED/COINS.AMT. SUBMIT TO OTHER INSURANCE FOR REMAINING PYMT					
452	16	THE QUANTITY OF INGREDIENTS USED IN THE COMPOUND DRUG MUST BE LISTED					
295	125	RECIPIENT PLACEMENT LEVEL IS NOT A VALID VALUE.					
296	35	MASTECTOMY BRAS (L8000) ARE LIMITED TO 2 PER PATIENT PER CALENDAR YEAR.					
297	125	INVALID MODIFIER ORDER. PLEASE CONTACT PROVIDER SERVICES WITH ANY QUESTIONS.					
298	35	DISPENSING FEE LIMITED TO ONCE PER LENS WITHIN TWO YEARS.					
299	35	MR GROUP THERAPY IS LIMITED TO 8 UNITS (2 HOURS) PER DAY.					
300	125	CLAIM DENIED. RESEARCH INDICATES INCORRECT BILLING.					
301	16	REBILL CORRECT CODE WITH TOTAL CHARGE.					
302	A1	CLAIM DENIED. REBILL PAPER CLAIM WITH REQUIRED ATTACHMENTS.					
303	16	THERAPY PROC CODE 9389 AND START DATE MUST BE IN ONE OF THE SURGICAL PROC FIELDS.					
304	17	ORIGINAL EOMB IS NEEDED IN ADDITION TO THE ADJUSTMENT EOMB TO PROCESS THIS CLAIM					
305	A1	CLAIM DENIED. MEDICARE'S ADJUSTMENT EOMB REQUIRED.					

306	A1	MEDICARE REQUIRES ADDITIONAL INFORMATION. REBILL WITH FINAL DECISION AND EOMB.
307	A1	NON-CONSECUTIVE DAYS MUST BE BILLED SEPARATELY.
308	4	THIS MODIFIER IS NOT VALID FOR THE SERVICE BILLED.
309	8	THESE CONSECUTIVE/SIMILAR CODES CANNOT BE BILLED SIMULTANEOUSLY (SAME DOS)
310	A1	THIS MODIFIER/MODIFIER COMBINATION IS NOT ACCEPTED BY VERMONT MEDICAID/OVHA.
311	141	OVERLAPPING ELIGIBILITY. RESUBMIT WITH EOMB AND AN ITEMIZED STATEMENT OF CHARGES
312	4	DETAIL DENIED. THIS PROCEDURE CODE REQUIRES A MODIFIER
313	4	THIS PROCEDURE CODE DOES NOT REQUIRE/ALLOW A MODIFIER
314	8	DIFFERENT MEDICATIONS INFUSED ON SAME DAY NEED MODIFIER 02 OR 03 ON CODE Y9873.
315	16	PLEASE INDICATE START DATE FOR COINSURANCE DAYS
316	97	A PORTION OF THIS CLAIM WAS PREVIOUSLY PAID. RESUBMIT SEPARATELY.
317	4	DIAGNOSIS INDICATES EPSDT MODIFIER REQUIRED ON PROCEDURE CODE
318	35	REHAB THERAPIES ARE LIMITED TO A MAXIMUM OF 1 HOUR PER DAY.
319	35	REPLACEMENT LIFTER SLING (EO621) IS LIMITED TO ONE PER 365 DAYS
320	17	THIS CROSSOVER SERVICE REQUIRES A PAPER CLAIM WITH MEDICARE'S EOMB ATTACHED.
321	17	REBILL A PAPER CLAIM WITH EOMB.
322	47	CRNA'S CAN ONLY BE PAID FOR MEDICARE/MEDICAID CROSSOVER CLAIMS.
323	A1	DOCUMENTATION INDICATES HOSPICE RELATED SERVICE. BILL HOSPICE PROGRAM.
324	42	SERVICES/QUANTITIES BEING BILLED DO NOT MATCH THE ALLOWED SVCS./AMTS.ON THE P.A.
325	A1	MEDICARE LIFETIME RESERVE DAYS NOT EXHAUSTED. MEDICAID SERVICE DENIED
326	17	NAME OF INSURANCE COMPANY NOT PRESENT ON ATTACHMENT
327	B18	THIS PROCEDURE CODE VALID FOR CROSS-OVER CLAIMS ONLY. MEDICAID/MEDICARE ELIG.
328	16	MEDICARE EOMB INDICATES LGHP COVERAGE. RESUBMIT WITH DENIAL/PAYMENT EOB.
329	97	THIS PROCEDURE CONSIDERED INCORPORATED WITHIN ANOTHER CODE PER CPT4 MANUAL.
330	97	THIS SERVICE COVERED WITHIN THE REIMBURSEMENT FOR THE INITIAL/PRIMARY PROCEDURE
331	16	DOCUMENTATION REQUIRED SUPPORTING TWO SEPARATE OPERATIVE SESSIONS SAME DOS.
332	4	FREE VACCINES/TOXOIDS (EG, STATE SUPPLIED) ARE TO BE BILLED WITH MODIFIER 52.
333	97	CLIENT ENROLLED IN PCPLUS PROGRAM BUT THERE IS NO TPOI SEGMENT FOR M04- INFO ONLY
334	8	HEALTHY BABIES PROCEDURE CODES MUST BE BILLED ON SEPARATE LINES FOR EACH DOS
335	52	BILLING/ATTENDING PHYSICIAN IS NON-PARTICIPATING NON-REIMBURSEABLE
336	62	PRIOR AUTHORIZATION HAS BEEN CHANGED RESUBMIT NEW CLAIM FOR PROCESSING
337	B22	OFFICE VISIT DENIED. ONLY 59425,59426 SHOULD BE BILLED WITH PREGNANCY DIAGNOSIS.
338	8	OFFICE VISIT DENIED. POSTPARTUM CARE SHOULD ONLY BE BILLED WITH CODE 59430
339	B19	PHARMACY CLAIM DENIED. MANUAL REVIEW REQUIRED PLEASE REBILL ON PAPER
340	16	ESRD-RELATED SVCS CANNOT BE BILLED BOTH DAILY AND MONTHLY FOR SAME TIME PERIOD.
341	35	MONTHLY ESRD-RELATED SVCS ARE LIMITED TO ONE CODE/CALENDAR MONTH PER RECIPIENT
342	A1	SERVICE DENIED AS BEING SAME OR INCLUDED IN ANOTHER ON SAME DAY

343	62	INP SVCS OVER 24 HOURS FOR CRT CLIENT WITH BEHAV HEALTH DIAG REQUIRE DDMHS PA				
344	4	THIS COMBINATION OF MODIFIERS USED IS NOT VALID FOR PROCEDURE CODE BILLED.				
345	125	ACCIDENT/OCCURENCE INDICATOR IS NOT A VALID VALUE				
346	125	OCCURENCE/ACCIDENT DATE IS NOT A VALID VALUE				
347	4	SUBMIT AS ADJUSTM'T TO PAID CLAIM WITH DOCUMENTATION OF MULTIPLE UNITS OR MOD.50				
348	125	BILL REPAIR CODES (12001-13300) AS ONE CODE FOR TOTAL LENGTH WITHIN EACH GROUP				
349	16	YOUR BILLED AMOUNT INDICATES INCORRECT CODE/BILLING				
350	62	PROCEDURE CODE NOT VALID OR NOT ALLOWED FOR USE WITH A GA VOUCHER				
351	125	THE INFORMATION ON THE INSURANCE ATTACHMENT IS ILLEGIBLE.				
352	29	CLAIM NOT SUBMITTED TO THIRD PARTY LIABILITY IN TIMELY MANNER				
353	B5	CLAIM DENIED. NO PARTICIPATION IN ELECTRONIC FUNDS TRANSFER PROGRAM				
354	18	EOMB STATES DUPLICATE SERVICE. RESUBMIT WITH INITIAL MEDICARE EOMB.				
355	73	THE NUMBER OF LEAVE DAYS ALLOWED PER CALENDAR YEAR HAVE BEEN EXHAUSTED				
356	125	NDC AGE MISMATCH				
357	38	PROVIDER NOT AUTHORIZED FOR THIS SERVICE.				
358	16	THE PATIENT STATUS IS NOT A VALID VALUE.				
359	16	MEDICARE COVERAGE INDICATOR IS NOT A VALID VALUE				
360	16	ENTER THE UNITS DISPENSED, INCLUDING THE NUMBER FOLLOWING THE DECIMAL.				
361	8	BILL THE ENCOUNTER PROCEDURE CODE FOR EACH DATE OF SERVICE.				
362	17	DATE THAT PHYSICIAN SIGNED THE CONSENT IS ILLEGIBLE. PLEASE CLARIFY.				
363	17	HYSTERECTOMY CONSENT FORM REQUIRED.				
364	17	PROVIDER SIGNATURE AND DATE ON CONSENT FORM MUST BE ON OR AFTER DATE OF SERVICE				
365	17	HYSTERECTOMY CONSENT FORM MUST BE SIGNED BY RECIPIENT PRIOR TO SURGERY.				
366	17	CONSENT FORM IS ILLEGIBLE. PLEASE CORRECT AND RESUBMIT IT WITH CLAIM.				
367	8	EACH PROCEDURE CODE MUST HAVE A CORRESPONDING DATE OF SERVICE (SURGICAL DATE).				
368	17	OPERATIVE NOTES/EXPLANATION ILLEGIBLE. PLEASE RESUBMIT WITH LEGIBLE INFORMATION.				
369	4	BILL BILATERAL PROCEDURE CODE ONCE ONLY WITH MODIFIER 50 AND ONE UNIT OF SERVICE				
370	125	PATIENT STATUS CODE IS NOT A VALID VALUE.				
371	42	HOLD BED DAYS NOT ALLOWED FOR LEVEL OF CARE H3 OR H4.				
372	16	RECIPIENT PLACEMENT LEVEL IS MISSING.				
373	42	LEAVE DAYS NOT ALLOWED WHEN RECIPIENT PLACEMENT LEVEL IS HO1 OR HO2				
374	16	MEDICARE COVERAGE INDICATOR IS MISSING				
375	42	HOLD BEDS ARE NOT ALLOWED FOR SWING BED CLAIMS.				
376	B5	BILLED DAYS ARE EQUAL TO MORE THAN ALLOWED FOR BILLED MONTH				
377	35	AS OF JULY 01, 1994 HOLD BED DAYS ARE LIMITED TO 6 CONSECUTIVE DAYS.				
378	35	NURSING HOME CLAIMS AND WAIVER SERVICES CAN ONLY BE BILLED ONE MONTH PER CLAIM.				
379	35	INPATIENT CLAIM DENIED AS IT WAS BILLED WITH NO ROOM CHARGE				

380	17	SIGNATURE REQUIRED FOR CHANGES MADE TO OTHER INSURANCE/MEDICARE ATTACHMENT.				
381	17	PLEASE PROVIDE DOCUMENTATION OF LETTER/CLAIM SENT TO OTHER INSURANCE COMPANY				
382	125	BLANKET DENIAL ATTACHMENT DATE IS MISSING OR IS VALID FOR ONE YEAR ONLY.				
383	17	OTHER INSURANCE ATTACHMENT REQUIRES BREAKDOWN OF PAYMENT AND DENIALS.				
384	17	ANOTHER PORTION OF YOUR POLICY IS TO BE CONSIDERED FOR COVERAGE.				
385	16	DENIAL CODE AND EXPLANATION OF INSURANCE E.O.B. CODE REQUIRED.				
386	16	RX NUMBER MISSING OR INVALID				
387	62	PRIOR AUTHORIZATION HAS BEEN CANCELLED.				
388	35	AMNIOCENTESIS LIMITED TO ONCE PER PREGNANCY.				
389	17	PLEASE GIVE REASON MEDICARE A BENEFITS WERE NOT PAID.				
390	17	INSURANCE COMPANY REQUIRES MORE INFORMATION.				
391	125	DATES ON INSURANCE/MEDICARE EOB DO NOT MATCH DATES OF SERVICE ON CLAIM.				
392	22	THIS SERVICE IS NOT COVERED BECAUSE OF NONCOMPLIANCE WITH OTHER INSURANCE RULES.				
393	16	PLEASE ATTACH A COPY OF YOUR MEDICARE DETERMINATION FORM				
394	18	EOB STATES DUPLICATE SERVICE. RESUBMIT WITH INITIAL INSURANCE ATTACHMENT.				
395	8	CLARIFY/INDICATE WHICH SERVICE (OR PART OF TOTAL) THIS UNLISTED CODE REPRESENTS.				
396	B13	NO BENEFITS DUE-MEDICAID POLICY THE SAME AS MEDICARE/INSURANCE FOR THIS SERVICE				
397	17	MEDICARE EOB SHEET IS INCOMPLETE OR INVALID. PLEASE CORRECT AND RESUBMIT				
398	102	INSURANCE ATTACHMENTS SHOW MAJOR MEDICAL PENDING.				
399	17	PLEASE RESUBMIT W/INVOICE SHOWING WHAT YOU PAID FOR SERUM OR OTHER EXPLANATION				
400	16	PLEASE BILL MEDICARE FIRST AND ATTACH A COPY OF PAYMENT OR DENIAL.				
401	125	MEDICARE (PART A) ATTACHMENT NOT VALID FOR SERVICES BILLED ON THIS CLAIM TYPE.				
402	57	SERVICE(S) ON INSURANCE ATTACHMENT ARE MISSING OR DO NOT MATCH CLAIM				
403	111	NO CROSS-OVER PAYMENT DUE. PROVIDER DID NOT ACCEPT ASSIGNMENT				
404	16	INDICATE AMOUNT PAID BY INSURANCE COMPANY ON THE FRONT OF THE CLAIM FORM.				
405	29	CLAIM/DETAIL DENIED, NOT FILED WITHIN THE TIME FRAME ALLOWED				
406	125	BENEFICIARY NAME ON INSURANCE/MEDICARE ATTACHMENT DOESNT MATCH CLAIM.				
407	96	SERVICE NON-COVERED FOR BENEFICIARY ENROLLED IN PDP (PHARMACY DISCOUNT PROGRAM)				
408	22	PLEASE BILL OTHER INSURANCE CARRIER FIRST AND ATTACH COPY OF PAYMENT OR DENIAL				
409	17	PLEASE PROVIDE DATES OF SERVICE ON INSURANCE ATTACHMENT, SIGN AND RESUBMIT.				
410	35	PSYCH ENCOUNTERS PER RECIP/PER BILLING PROVIDER/PER CALENDAR YEAR EXCEED LIMIT				
411	141	RECIPIENT INELIGIBLE FOR A PORTION OF DAYS BILLED				
412	141	PATIENT UNAUTHORIZED FOR NURSING HOME FOR A PORTION OF DAYS BILLED.				
413	22	RECIPIENT HAS ANOTHER INSURANCE TO BE CONSIDERED.				
414	16	PLEASE RESUBMIT INDICATING NUMBER OF TESTS PERFORMED.				
415	17	TREATMENT OF ACCIDENTAL INJURY MUST BE PROVIDED WITHIN 72 HOURS OF THE ACCIDENT				
416	B22	DIAGNOSIS/SITUATION DOES NOT WARRENT EMERGENCY ROOM SERVICE.				

417	B6	THIS "LOCK-IN" RECIPIENT CAN ONLY BE TREATED BY SPECIFIC PROVIDER			
418	29	CLAIM PAST TIMELY FILING LIMITATION			
419	17	PLEASE PROVIDE NAME OF BENEFICIARY ON INSURANCE ATTACHMENT, SIGN & RESUBMIT.			
420	A1	WHEN MEDICARE MAKES PAYMENT, BILL ON UB92. OTHERWISE, BILL ON A NURSING HOME TAD			
421	111	NO COINSURANCE OR DEDUCT. DUE. PROVIDER DID NOT ACCEPT ASSIGNMENT FROM MEDICARE			
422	16	PLEASE RESUBMIT WITH SUPPLIER'S/MANUFACTURER'S INVOICE ATTACHED			
423	29	PRIOR AUTHORIZATION IS EXHAUSTED WITH THIS PAYMENT.			
424	17	PLEASE SEND CLAIM/ATTACHMENTS TO OVHA FOR CONSIDERATION OF LATE BILLING.			
425	62	PLEASE SUBMIT CLAIM/ATTACHMENTS TO OVHA FOR REQUIRED PRIOR AUTHORIZATION.			
426	62	PAYMENT CANNOT BE MADE WHEN PA IS STATUS "I" (INFORMATION REQUIRED BY REVIEWER).			
427	62	MEDICAL NECESSITY AND PRIOR AUTHORIZATION REQUIRED			
428	17	REQUIRED ATTACHMENT MUST HAVE AUTHORIZED SIGNATURE.			
429	59	VT MEDICAID REIMBURSEMENT FOR MULTIPLE SURGERY APPLIES TO TWO PROCEDURES ONLY.			
430	17	"UNLISTED" PROCEDURES REQUIRE DOCUMENTATION. RESUBMIT W/NOTES AND/OR EXPLANATIC			
431	57	INFORMATION ON MEDICAL NECESSITY FORM DOES NOT MATCH CLAIM			
432	17	PLEASE RESUBMIT WITH A MEDICAL NECESSITY FORM.			
433	B19	PRICING WILL BE OR WAS MANUALLY REVIEWED			
434	17	CLAIM DENIED-REQUESTED DOCUMENTATION NOT RECEIVED			
435	125	HCPCS HAS A SPECIFIC CODE FOR THIS MEDICATION. SEE THE CURRENT HCPCS LISTING.			
436	17	DETAIL DENIED. INADEQUATE OR INSUFFICIENT INFORMATION PROVIDED			
437	125	INAPPROPRIATE PROCEDURE/REVENUE CODE. REFER TO YOUR LIST OF ALLOWED CODES.			
438	15	PA DOES NOT MATCH. VERIFY INFORMATION SENT TO PRO CONTRACTOR/OVHA/ISSUER OF PA.			
439	42	PRIMARY SURGERY IS MANUALLY PRICED AT 100% OF ALLOWED AMOUNT			
440	42	SECONDARY SURGERY IS MANUALLY PRICED AT 50% OF ALLOWED AMOUNT			
441	52	ASSISTANT AT SURGERY IS PROHIBITED WITH THIS PROCEDURE CODE, PER FEDERAL POLICY			
442	16	PLEASE REMOVE OTHER INSURANCE AMOUNT IF IT IS NOT FROM A THIRD PARTY CARRIER.			
443	B18	WAIVER CASE MANAGEMENT SERVICES NOT ALLOWED FOR DATES OF SERVICE BILLED.			
444	125	THE APPROPRIATE CODE FOR A COMPOUND DRUG IS 99100-1001-00			
445	17	NOTES/CONSENT INCOMPLETE AND/OR ILLEGIBLE. PLEASE CORRECT AND RESUBMIT.			
446	15	REHAB TX START DATE MISSING OR > 4 MONTHS BEFORE DOS (> 4 MOS OF REHAB NEEDS PA)			
447	17	NOTES/CONSENT/INVOICE/ATTACHMENT(S) INVALID.			
448	125	ATTENDING PROVIDER NUMBER MUST BE AN INDIVIDUAL PROVIDER NUMBER.			
449	16	REHABILITATIVE / HOSPICE SCS SHOULD BE BILLED AS 1 UNIT PER DATE OF SERVICE			
450	8	NOT ALLOWED TO BILL THIS CODE AS YOU ARE NOT AUTHORIZED FOR THE LAB SPECIALTY			
451	16	COMPOUNDS NEED INGREDIENTS, INGREDIENT NDC'S, QUANTITY AND COMPUTATION OF COST.			
610	16	PSYCHOTHERAPY NOT TO BILL IN UNITS GREATER THAN ONE.			
453	125	NOT BILLED ACCORDING TO COMPOUND PRICING FORMULA			

454	97	ANESTHESIA BY THE OPERATING MD IS INCLUDED WITHIN THE SURGERY CODE PAYMENT			
455	B5	PROCEDURE MAY BE BILLED IN ONLY ONE UNIT OF SERVICE PER SAME DATE OF SERVICE.			
456	125	THIS SERVICE REQUIRED TO BE PROVIDED IN SESSIONS OF AT LEAST ONE-HALF HOUR(U=2)			
457	125	NDC INDICATES THE PREGNANCY INDICATOR MUST BE A 1			
458	42	CLAIM PRICED AT VERMONT MULTI-SOURCE DRUG PRICE			
459	16	TAPE BILLING PROVIDER NOT ELIGIBLE TO BE BILLED FROM THIS SUBMITTER.			
460	6	NON-COVERED SERVICE-RECIPIENT AGE 21 OR OVER			
461	4	LAB INDICATOR INDICATES PROCEDURE WAS PROCESSED OFF-SITE. MODIFIER 26 REQUIRED.			
462	63	PROCESSING ERROR, EDS IS RESUBMITTING THIS CLAIM			
463	17	TREATMENT AND PLAN OF CARE MUST BE DOCUMENTED			
464	16	DIAGNOSIS RESTRICTED TO "ADULTS". STATEMENT NEEDED TO VERIFY THIS DIAGNOSIS.			
465	7	PROCEDURE CODE IS NOT CONSISTENT WITH RECIPIENT'S SEX			
466	6	PROCEDURE CODE/SERVICE NOT ALLOWED FOR THIS AGE (OF BILLED BENEFICIARY).			
467	8	REVENUE CODE 762 IS THE CORRECT REVENUE CODE FOR OBSERVATION SERVICES.			
468	8	CODE 59430 IS FOR THE MOTHER'S SIX-WEEK POSTPARTUM CHECK UP.			
469	17	MEDICAL NECESSITY SIGNATURE/DATE IS MISSING/INVALID/ILLEGIBLE.			
470	8	99 CODE NOT PERMITTED UNLESS PRIMARY SURGEON USED OR WAS PAID FOR SAME PROC CODE			
471	16	FRAMES AND LENSES ARE ONLY BILLABLE BY SOLE-SOURCE SUPPLIER.			
472	52	ASSIST. SURGEON CANNOT BE PAID UNTIL PRIMARY SURGEON HAS BEEN PAID FOR THIS CODE			
473	8	DENTAL PROCEDURE D0275 MAY ONLY BE PAID WHEN BILLED WITH PROCEDURE D0272			
474	17	PLEASE RESUBMIT WITH COMPLETE HOSPITAL RECORD			
475	16	DATE OF DELIVERY MUST BE ON CLAIM WHEN BILLING D&C FOR POST PARTUM HEMORRHAGE			
476	10	DIAGNOSIS CODE IS NOT CONSISTENT WITH THE RECIPIENT'S SEX.			
477	18	THIS COMPOUND DRUG IS A DUPLICATE SERVICE PER RX AND REFILL NUMBER.			
478	125	ASSISTANT SURGEON MUST USE THE SAME PROCEDURE CODE USED BY THE PRIMARY SURGEON			
479	62	PSYCHIATRIC/EMOTIONAL DISORDERS/ SUBSTANCE ABUSE REQUIRE PA FROM PRO CONTRACTOR			
480	16	EXPLANATION REQUIRED RE. MEDICAL NEED FOR GENERAL ANESTHESIA WITH THIS PROCEDURE			
481	35	D&C FOR POSTPARTUM HEMORRHAGE NOT COVERED IF PERFORMED WITHIN 7 DAYS OF DELIVERY			
482	17	RESUBMIT WITH AUTHORIZED SIGNATURE FROM DDH WHEN YOU ARE BILLING TOOTH (33)			
483	16	AMOUNT PAID BY OTHER INSURANCE SHOULD BE INDICATED IN THE PRIOR PAYMENT FIELD.			
484	97	THESE SERVICES ARE COVERED IN FEE PAID FOR TOTAL OB CARE			
485	16	BENEFICIARY NUMBER MISSING ON MEDICAL NECESSITY FORM.			
486	8	THE ONLY OVHA-COVERED CHIROPRACTIC SERVICE IS SPINAL MANIPULATION (A2000)			
487	16	MODIFIER 22 NEEDS PROCEDURE NOTES AND AN EXPLANATION TO JUSTIFY INDIVIDUAL CONSIDERATION			
488	96	NITROUS OXIDE NONCOVERED FOR PROVIDER/PATIENT CONVENIENCE.			
489	8	CHIROPRACTIC MANIPULATION IS COVERED ONLY FOR SUBLUXATION OF THE SPINE.			
490	125	THIS NDC IS NOT VALID FOR DATE OF SERVICE BILLED.			

491	16	INDIVIDUAL'S EXPECTED DATE OF DELIVERY (SEE CONSENT FORM) NEEDED FOR PROCESSING.				
492	125	EPSDT INDICATOR MUST BE YES IF EPSDT PROCEDURE CODES ARE BILLED.				
493	17	MULTIPLE ERRORS ON CONSENT FORM. PLEASE CONTACT COMMUNICATIONS FOR ASSISTANCE				
494	B18	SEPARATE ER VISITS MUST BE BILLED SEPARATELY. DO NOT COMBINE INTO ONE CLAIM/BILL				
495	16	RECIPIENT'S SIGNATURE ON CONSENT FORM MUST BE ON OR BEFORE DATE OF SERVICE				
496	17	DATES OF SERVICE ON CLAIM AND CONSENT FORM DISAGREE.				
497	35	RECIPIENT MUST BE 21 TO LEGALLY SIGN THE FEDERAL STERILIZATION CONSENT FORM.				
498	17	DATE OR DATES ON CONSENT ARE ILLEGIBLE. PLEASE CLARIFY THEM AND RESUBMIT.				
499	17	STERILIZATION CAN BE PAID ON 31ST DAY-30 FULL DAYS MUST PASS AFTER PATIENT SIGNS				
500	35	STERILIZATION MUST BE 180 DAYS OR LESS FROM DATE CONSENT SIGNED BY RECIPIENT				
501	8	PROCEDURE ON CONSENT FORM MUST AGREE WITH CLAIM				
502	17	CONSENT FORM INCOMPLETE				
503	17	DATE OF HOSPITAL ADMISSION ON OCCUPANCY CERTIFICATION FORM IS INVALID.				
504	16	RESUBMIT WITH OP NOTES &/OR EXPLANATION OF PROCEDURE/SITUATION.				
505	57	DATA SUBMITTED DOES NOT SUBSTANTIATE PROCEDURE (OR REVENUE CODE) BILLED.				
506	B7	OUR FILE SHOW NO N.H. AUTHORIZATION FOR DATE OF SERVICE.				
507	30	APPLIED INCOME NOT CURRENT ON ELIG FILE, CONTACT DISTRICT OFFICE FOR CORRECTION				
508	16	RESUBMIT WITH OPERATIVE/PROCEDURE NOTES, MED/SURG HISTORY & DISCHARGE SUMMARY				
509	78	CLAIM DENIED. LEAVE DAYS NOT COVERED				
510	73	CLAIM DENIED. MAXIMUM LEAVE DAYS EXCEEDED.				
511	16	PLEASE RESUBMIT WITH EXPLANATION OF MEDICAL NECESSITY				
512	50	BENEFICIARY NOT AUTHORIZED FOR THE RPL FOR ALL/PORION OF DAYS BILLED.				
513	97	CLAIM DENIED. INDEPENDENT LAB HAS ALREADY BEEN PAID FOR THIS SERVICE.				
514	50	SUBMITTED DATA DOES NOT JUSTIFY MEDICAL NECESSITY OF ITEM(S) PROVIDED.				
515	35	DENIED. STERILIZATION CONSENT MUST BE GIVEN AT LEAST 72 HOURS PRIOR TO PROCEDURE				
516	17	PLEASE SUBMIT WITH ADMISSION HISTORY (INCL.SURGICAL) AND DISCHARGE SUMMARY.				
517	17	PLEASE SUBMIT WITH DATA AND EXPLANATION SUBSTANTIATING PROCEDURE/TIME/UNITS				
518	35	THIS ITEM LIMITED TO ONE UNIT PER YEAR (365 DAYS) PER RECIPIENT				
519	16	PLEASE RESUBMIT EXPLAINING HOW MUCH TIME WAS SPENT FOR THE BILLED PROCEDURE				
520	16	PLEASE RESUBMIT EXPLAINING WHY D AND C WAS MEDICALLY NECESSARY.				
521	50	DATA SUBMITTED DOES NOT SUBSTANTIATE MEDICAL NECESSITY				
522	50	D&C NOT MEDICALLY NECESSARY. REBILL, OMITTING D&C-RELATED SERVICES.				
523	16	PROCEDURE 99360 REQUIRES DOCUMENTATION OF MD'S TIME & SERVICES BEYOND THE NORMA				
524	17	PRIOR AUTHORIZATION IS NOT VALID.				
525	96	BENEFITS FOR REMOVAL/REPAIR OF ORGANS INJURED DURING SURGERY ARE NOT PROVIDED				
526	16	RESUBMIT WITH LAB AND/OR XRAY RESULTS				
527	16	ALL ITEMS BILLED MUST BE DOCUMENTED AND JUSTIFIED ON MEDICAL NECESSITY FORM.				

528	62	JUSTIFICATION REQUIRED FOR MEDICAL NECESSITY FOR THIS LENGTH OF STAY				
529	16	RELEVANT HISTORY REQUIRED FOR PROCESSING (HOSPITAL,OFFICE,ETC.REORDS SHOWING HX				
530	42	PAID HOME VISITS ARE LIMITED TO 24 DAYS/YEAR; MORE THAN 2 DAYS/MONTH NEED REVIEW				
531	17	DOCUMENTATION FOR GRAFT CODES MUST INCLUDE SIZE OF DEFECT, IN SQUARE CENTIMETERS				
532	15	OUR FILES INDICATE AUTHORIZATION FOR DIFFERENT PROVIDER FOR ALL OR PART OF DOS				
533	B19	CLAIM SUSPENSION DUE TO DSW REVIEW OF PER DIEM RATES.				
534	23	CLAIM HAS ALREADY BEEN PAID BY INSURANCE CARRIER.				
535	A2	MEDICARE DENIAL IS "CO" (CONTRACTUAL OBLIGATION). MEDICAID SHOULD NOT BE BILLED.				
536	8	STERILIZATION-RELATED SERVICES (INCL.W222)ALLOWED OUTPATIENT ONLY.				
537	73	LEAVE DAYS ON NURSING HOME CLAIM DO NOT MATCH FROM/THRU DATES OF SERVICE.				
538	35	NORPLANT CONTRACEPTIVE SYSTEM COVERED ONCE IN 5 YEARS, PER RECIPIENT.				
539	35	APPLIANCE THERAPY IS LIMITED TO ONCE PER TWO YEARS				
540	16	BENEFICIARY NUMBER IS MISSING				
541	16	LAB INDICATOR IS MISSING				
542	8	NON-INJECTED MEDS FOR HOME USE ARE TO BE BILLED BY PHARMACY PROVIDERS				
543	17	ADMISSION CODE "1" IS NOT SUPPORTED BY THE ATTACHED DOCUMENTATION.				
544	62	PRIVATE ROOM CHARGES REQUIRE PRIOR AUTHORIZATION OF MEDICAL NECESSITY.				
545	17	THE SIGNATURE IS MISSING ON THE OCCUPANCY CERTIFICATION FORM.				
546	16	ADJUST TO INCLUDE OUTPATIENT PRE-OP SERVICES ON INPATIENT BILL/CLAIM.				
547	125	BILLED VS. ALLOWED AMOUNTS INDICATE INVALID PROCEDURE OR MODIFIER OR UNITS.				
548	59	SEE ANESTHESIA SECTION OF CURRENT CPT FOR GENERAL/REGIONAL ANESTHESIA SERVICES				
549	17	SPECIAL PROGRAM/EPSTD/FAMILY PLANNING INDICATOR IS NOT A VALID VALUE				
550	8	ICD-9-CM PROCEDURE CODES (VOLUME 3) ARE NOT ALLOWED ON HCFA CLAIMS.				
551	8	REVENUE CODES 915 AND 918 ARE RESTRICTED TO PROVIDER # 0470R03,0470R18, 1006874				
552	17	INSURANCE ATTACHMENT SHOWS CLAIM PENDING. RESUBMIT WITH FINAL DECISION.				
553	111	MANUFACTURER NOT PARTICIPATING IN VERMONT SCRIPT REBATE PROGRAM				
554	16	AS OF 07/01/95 AN OCCUPANCY CERT FORM MUST BE ATTACHED TO HOLD BED SERVICES				
555	125	SPLIT & RESUBMIT AS CROSSOVER AND STRAIGHT CLAIM PER MEDICARE EOMB				
556	125	BILL SAME CODE ONLY ONCE, WITH MULTIPLE UNITS TO INCLUDE ALL SERVICES.				
557	16	THE SIGNATURE DATE ON THE OCCUPANCY CERTIFICATION FORM IS MISSING.				
558	111	BEHAVIORAL HEALTH SERVICE DENIED. BENEFICIARY NOT CRT ON DOS.				
559	35	THIS BRATTLEBORO RETREAT PROVIDER # RESTRICTED TO INPATIENT AGE 0-21 PA REQ				
560	15	PRIOR AUTHORIZATION IS FOR A DIFFERENT PROVIDER/PROVIDER NUMBER.				
561	62	AUTHORIZATION BY DDH REQUIRED FOLLOWING COMPLETION OF PROCEDURE.				
562	35	ORAL EVALUATIONS (D0120-50) ARE LIMITED TO ONE PER PATIENT PER PROVIDER PER DAY.				
563	99	AMOUNT PAID BY MEDICARE SHOULD BE INDICATED IN THE PRIOR PAYMENT FIELD.				
564	17	OCCUPANCY CERT FORM SHOULD INDICATE 100% OCCUPANCY FOR EACH HOLD BED DATE ON T/				

565	8	THIS SURGERY IS NOT COVERED FOR AMBULATORY SURGICAL CENTERS			
566	125	INCORRECT BILLING OF MEDICARE EXHAUSTED BENEFITS.CONTACT PROV. SERV. FOR HELP.			
567	17	PLEASE BILL ONE DATE OF SERVICE ON OUTPATIENT DETAILS AND INCLUDE MONTH-DAY-YEAR			
568	A1	CLAIM DENIED. BILLED AMOUNT EXCESSIVE FOR SERVICES SUBMITTED. REVIEW AND REBILL			
569	35	OADAP RESIDENTIAL DETOXIFICATION LIMITED TO 7 DAYS PER ADMISSION			
570	17	OUR HISTORY FILES SHOW NO BILLING FOR MOTHERS DELIVERY ON UB92 CLAIM FORM.			
571	88	CLAIM DETAIL DENIED. NO CURRENT CLIA IDENTIFICATION ON FILE.			
572	125	ADMISSION DATE SHOULD BE EQUAL TO OR PRIOR TO THE HEADER FROM DATE OF SERVICE.			
573	141	OUR FILE SHOWS RECIPIENT NOT AUTHORIZED FOR ALL DATES BILLED. PATIENT EXPIRED			
574	141	MD PRESCRIPTION GIVEN DOES NOT COVER ALL THE DATES OF SERVICE BEING BILLED			
575	16	DRUGS FOR HOME/SCHOOL MUST BE BILLED AS ONE LINE FOR TOTAL UNITS.RECOUP & REBILL			
576	9	PRIMARY DIAGNOSIS IS NOT CONSISTENT WITH RECIPIENT'S AGE			
577	125	THIS CLAIM TYPE REQUIRES A DETAIL DATE OF SERVICE FOR EACH LINE BILLED.			
578	62	PRESCRIBING PHYSICIAN ON CLAIM DOES NOT MATCH PA.			
579	17	BRAND CERTIFICATION INDICATOR NOT A VALID VALUE			
580	35	MAINTENANCE ON OXYGEN CONCENTRATORS LIMITED TO ONCE EVERY TWO MONTHS			
581	16	RECIPIENT NAME IS MISSING			
582	62	AUTHORIZATION OR MANUAL PRICING IS REQUIRED BY OFFICE OF ORAL HEALTH.			
583	96	DATE OF DISCHARGE OR DEATH NOT REIMBURSEABLE (WHEN BILLED DAYS EQUAL ZERO)			
584	A2	ECS PROVIDER NEEDS TO SUBMIT TEST CLAIMS PRIOR TO PRODUCTION SUBMISSION.			
585	16	MEDICARE PAID AMOUNT IS ILLEGIBLE			
586	B22	PARTIAL HOSPITALIZATION FOR CRT CLIENT WITH BEHAVIORAL HEALTH DIAG REQUIRES PA			
587	17	NOTICE OF DECISION SPENDDOWN ATTACHMENT INVALID			
588	B20	REIMBURSEMENT HAS ALREADY BEEN MADE TO ANOTHER PROVIDER IN THEIR PER DIEM RATE.			
589	35	OADAP INDIVIDUAL TREATMENT (X9000) LIMITED TO 5 UNITS (1 HOUR,15 MINS) PER DOS			
590	119	MAXIMUM DOLLAR AMOUNT ALLOWED PER DAY HAS BEEN MET			
591	62	CARDIAC REHAB REQUIRES DSW PA FOR MORE THAN 36 SESSIONS			
592	111	CLAIM DENIED. NO ELECTRONIC FUNDS TRANSFER AGREEMENT ON FILE.			
593	24	CLAIM HAS MULTIPLE ERRORS. CONTACT PROVIDER SERVICES IF YOU NEED ASSISTANCE			
594	125	CLAIM MUST STATE "BILLING FOR BABY UNDER MOTHER'S I.D. NUMBER"			
595	35	ADAP GROUP OUTPATIENT (X9001 OR X9011) IS LIMITED TO 8 UNITS (2 HOURS) PER DOS			
596	35	ADAP GROUP OUTPATIENT (X9001) MUST BE PROVIDED FOR AT LEAST ONE-HALF HOUR (U=2)			
597	125	RECIPIENT NAME ON CLAIM DOES NOT MATCH NAME ON NOTES AND/OR CONSENT.			
598	42	COCHLEAR (RE)PROGRAMMING LIMITED TO A MAXIMUM OF 18 HOURS PER 365 DAYS/PATIENT			
599	125	BENEFICIARY NAME IS MISSPELLED.			
600	16	DOCUMENT DRUG'S NAME,STRENGTH,EXACT QUANTITY USED,AND ROUTE OF ADMINISTRATION.			
601	47	RADIOLOGY SERVICES DONE FOR THE PURPOSE OF COMPARISON ARE NOT COVERED			

602	24	CLAIM PAID AMOUNT GREATER THAN BILLED DUE TO PAYMENT POLICY			
603	16	COPY OF PRO'S "RETROSPECTIVE REVIEW CASE SUMMARY" REQUIRED FOR LATE BILLING.			
604	62	MORE THAN ONE HOSPITAL VISIT PER DAY,SAME DIAGNOSIS AND PROVIDER REQUIRES P.A.			
605	119	NURSING HOME SERVICE PRICED AT 30 DAYS PER CALENDAR YEAR - VHAP RECIPIENT			
606	17	PLEASE RESUBMIT YOUR NEW CLAIM WITH YOUR RURAL HEALTH PROVIDER NUMBER			
607	35	DME COMPRESSOR NEBULIZERS (E0570) ARE LIMITED TO ONE PER 3 YEARS.			
608	35	OBSTETRICAL DELIVERY PAYMENTS ARE LIMITED TO ONCE IN NINE MONTHS.			
609	47	THIS OPTOMETRY SERVICE IS NON-COVERED PRIOR TO DOS 7-1-89.			
768	35	D0272 AND D0274 LIMITED TO ONE UNIT PER 180 DAYS FOR ANY PROVIDER.			
611	47	PRESCRIPTION+FIT.OF CONTACT LENS CANNOT BE PAID UNTIL LENS ITSELF PAID/APPROVED.			
612	35	DISPENSING FEES FOR FRAMES,CASE AND LENSES MAY ONLY BE BILLED ONE TIME / 2 YEARS			
613	35	COST OF LENSES MAY ONLY BE BILLED ONE TIME PER TWO YEARS			
614	47	BOTH SURGICAL & MEDICAL BENEFITS NOT ALLOWED FOR SAME VISIT/SERVICE.			
615	16	(Y0069) RECIPIENT NOT ENROLLED WITH ATTENDING PROVIDER AS PCP ON DOS			
616	40	DOCUMENTATION SUBMITTED DOES NOT JUSTIFY NEED FOR AIR AMBULANCE -			
617	17	SIGNATURE DATE ON OCCUPANCY CERTIFICATION FORM IS PRIOR TO DOS ON CLAIM.			
618	16	TYPE OF BILL INDICATES INPATIENT CLAIM WHICH SHOULD HAVE ROOM CHARGES BILLED.			
619	31	THE MEDICAID ID NUMBER ON OCCUPANCY CERTIFICATION FORM DOES NOT MATCH CLAIM.			
620	17	BENEFICIARY NEEDS TO PROVIDE OVHA WITH NAME OF CURRENT INSURANCE COMPANY.			
621	8	D3310 LIMITED TO TEETH 6,7,8,9,10,11,22,23,24,25,26,27,56,57,58,59,60,61,62,63,64,65,66,67			
622	96	THIS IS A NON-COVERED SERVICE FOR THIS PROVIDER			
623	8	OOH COVERS SEALANTS D1352 ONLY ON TEETH A, J, K, T, 04, 05 12 13 20 21 28 29			
624	42	THE MAX ALLOWED UNITS/\$\$ FOR THIS HEALTHY BABIES ASSESSMENT HAS BEEN REACHED.			
625	125	REVENUE CODE IS NOT CONSISTENT WITH THE PROVIDER TYPE - VERIFY PROVIDER # BILLED			
626	8	DENTAL PROC CODES D3230, D3240, D7111 ALLOW PRIMARY TEETH A TO T, AS TO TS			
627	16	EPSDT/FAMILY PLANNING INDICATOR IS NOT A VALID VALUE			
628	125	TOOTH SURFACE CODE IS NOT A VALID VALUE			
629	8	SEALANTS COVERED ONLY ON TOOTH #'S 02 03 14 15 18 19 30 31 OR SURFACE IS INVALID			
630	16	DDMHS INDICATES NO CRT STATUS FOR DATES OF SERVICE.			
631	125	PROVIDER SPECIALTY/REVENUE CODE MISMATCH			
632	16	DIAGNOSIS CODE BILLED IS NOT SUBSTANTIATED BY DOCUMENTATION.			
633	16	OTHER INSURANCE PYMT NOT APPLICABLE FOR HWU (ACCS) & HDR (DAY HEALTH REHAB)			
634	16	THE NUMBER OF UNITS BILLED IS NOT DOCUMENTED BY THE NOTES &/OR CLAIMS' HISTORY.			
635	52	CASES INVOLVING CO-SURGERY CANNOT ALSO BILL ASSISTANT SURGEON CHARGES			
636	125	ELECTRONIC VOID ADJUSTMENT ACCEPTED			
637	17	THE FACILITY NAME IS MISSING ON THE OCCUPANCY CERTIFICATION FORM.			
638	42	THE MAXIMUM ALLOWED (\$176/30DAYS) FOR INFUSION PUMP RENTAL HAS BEEN REACHED.			

639	35	MASTECTOMY FORMS (L8020 & L8030) ARE LIMITED TO ONE PER SIDE PER CALENDAR YEAR.		
640	35	RESPIRE FOR CAREGIVERS(W0114) IS LIMITED TO 1 PER DAY, 2 PER MONTH.		
641	35	IEP/ISFP DEVELOPMENT (X0070) IS LIMITED TO A MAXIMUM OF TWO PER 275 DAYS.		
642	B20	A PORTION OR ALL OF THESE DAYS WERE PAID AS A NURSING HOME CLAIM		
643	110	DATE OF SERVICE IS AFTER THE JULIAN DATE CLAIM WAS RECEIVED OR DOS IS IN FUTURE.		
644	17	THE SIGNATURE DATE ON THE OCCUPANCY CERTIFICATION FORM IS ILLEGIBLE.		
645	35	D.O.E. PHYSICIAN IEP W0069YE IS LIMITED TO TWICE PER 305 DAYS.		
646	16	THE EFFECTIVE AND THRU DATES OF SERVICE MUST BE THE SAME MONTH AND YEAR.		
647	17	THE RECIPIENT NAME ON THE OCCUPANCY CERTIFICATION FORM DOES NOT MATCH THE CLAIM.		
648	62	CLAIM DENIED. DATE OF SERVICE ON CLAIM IS PRIOR TO PROCEDURE DATE ON P.A.		
649	8	USE ZEROES FOR 2ND, 3RD AND 4TH CHARACTERS WHEN BILLING PROCEDURE CODE G0001.		
650	30	THIS BENEFICIARY IS NOT ENROLLED IN PCPLUS FOR THIS DATE OF SERVICE		
651	17	ATTACHMENT MUST STATE IF PATIENT ABLE TO BE SAFELY TRANSPORTED BY OTHER MEANS		
652	B12	PATIENT'S SURGICAL HISTORY (NAME OF PROCEDURES, DATES & PROVIDERS) REQUIRED		
653	16	TOTAL DAYS BILLED ARE NOT EQUAL TO COVERED DAYS IN BOX 7 ON CLAIM.		
654	35	96117 IS LIMITED TO 8 UNITS - HOURS PER YEAR - 365 DAYS		
655	125	MODIFIERS RT, LT & RTL NOT VALID AND/OR NOT ACCEPTED ON THIS PROCEDURE CODE		
656	96	AMBULANCE SERVICE PAID FOR BY HOSPITAL WHERE TRIP ORIGINATES. CLAIM DENIED.		
657	8	PLEASE SUBMIT PROCEDURE D7880 FOR RECIPIENTS OVER 21 ON A HCFA-1500 CLAIM FORM.		
658	24	NO PAYMENT DUE, CAPITATED PAYMENT RECEIVED FROM PRIMARY INSURANCE		
659	35	PERIODONTAL SCALING & ROOT PLANING (D4341) IS LIMITED TO 4 UNITS (QUADRANTS)/YR.		
660	63	PROVIDER REQUESTED ADJUSTMENT(UNIT DOSE) - ALL UNITS RETURNED - CLAIM RECOUPED		
661	35	WAIVER RESPIRE CARE LIMITED TO 30 DAYS PER CALENDAR YEAR PER BENEFICIARY		
662	35	NURSING HOME NOT AT MAX OCCUPANCY FOR ALL/PORTION OF HOLD BED DAYS BILLED.		
663	42	PAYMENT REDUCED TO MAXIMUM ALLOWABLE AMOUNT FOR PDP (PHARMACY DISCOUNT PROGR		
664	35	THIS CLAIM WILL EXCEED THE 24 LEAVE DAYS ALLOWED PER CALENDAR YEAR.		
665	97	PAYMENT FOR THIS SERVICE IS INCLUDED IN THE ASC PAYMENT RECEIVED		
666	8	THE ONLY DENTAL PROCEDURE CODE ALLOWED ON THE HCFA CLAIM TYPE IS D7880.		
667	31	THE RECIPIENT MEDICAID ID NUMBER IS MISSING ON THE OCCUPANCY CERTIFICATION FORM.		
668	17	SIGNATURE OTHER THAN PATIENT'S REQUIRES COMPETENCY STATEMENT, PER FEDERAL REG'S		
669	B20	CLAIM PAID ZERO DUE TO VA DENTAL CLINIC PROGRAM PROCESSING.		
670	17	AMBULANCE ATTACHMENT NOT SIGNED BY PHYSICIAN, RN OR LPN CERTIFYING MED NECESSITY		
671	31	CHOICES FOR CARE ELIGIBILITY DOES NOT MATCH SERVICE AND/OR DOS, PLEASE VERIFY AND R		
672	17	THIS CLAIM IS ALREADY AWAITING REVIEW. TECHNICAL DENIAL AS DUPLICATE SUBMISSION		
673	125	87536 AND ITS COMPONENT CODES CANNOT BE BILLED SIMULTANEOUSLY.		
674	8	MODIFIER 51 ALLOWED ONLY ON SECONDARY SURGICAL CODE THAT REQUIRES PRIOR AUTH.		
675	16	ROUTINE MAMMOGRAPHY SCREENING (76092) IS NOT REIMBURSEABLE UNDER BCCT PROGRAM		

676	125	BILLING PROVIDER NUMBER IS ONLY AUTHORIZED TO BE THE ATTENDING PROVIDER			
677	8	D3320 ALLOWS TOOTH # 4, 5, 12, 13, 20, 21, 29, 29, 54, 55, 62, 63, 70, 71, 78, 79			
678	125	THE HOSPITAL BILLED THIS STAY AS OUTPATIENT. INPATIENT SERVICES CANNOT BE PAID.			
679	35	THE MAXIMUM OF \$200 PER DAY PER CLIENT FOR MR SERVICES HAS BEEN MET			
680	96	CLAIM DENIED. EQUIPMENT PURCHASES INCLUDE REIMBURSEMENT FOR ASSEMBLYING.			
681	35	REPAIRS LTD TO ONCE/YR PER AID. SPECIFY BOTH SERIAL #S & DATES IF DIFFERENT AIDS			
682	17	CONTACT LOCAL SOCIAL WELFARE OFFICE FOR SPEND DOWN LETTER AND RESUBMIT CLAIM.			
683	125	THE NUMBER OF UNITS ON PHARMACY CLAIMS IS LIMITED TO FOUR DIGITS.			
684	38	THIS CLAIM IS DENIED-NO AUTHORIZATION TO SUBMIT ELECTRONICALLY - CONTACT EDS			
685	8	DAY HOSPITAL (X2876) CANNOT BE BILLED WITH CHEMO,GROUP,PSYCHOTHERAPY OR DAY RX.			
686	2	CLAIM PROCESSED AS MEDICARE PART A. CLAIM RECOUPED. RESUBMIT AS MEDICARE PART B.			
687	18	DENIED FOR THERAPEUTIC DUPE			
688	141	OUR FILES INDICATE RECIPIENT NOT ENROLLED IN HOSPICE FOR ALL/PORION OF DAYS.			
689	62	PRIOR AUTHORIZATION / DIVISION FOR CHILDREN WITH SPECIAL HEALTH NEEDS REQUIRED			
690	35	FEDERALLY QUALIFIED HEALTH CENTER CODES W1040,W1050, T1015 ARE LIMITED TO ONE PER			
691	42	BILLED AMOUNT EXCEEDS NORM. VERIFY SERVICE CODE, UNITS & USUAL/CUSTOMARY CHARGE			
692	16	CLARIFICATION OF MEDICARE/INSURANCE DENIAL NEEDED TO PROCESS THIS CLAIM.			
693	125	NON-MANAGED CARE RECIPIENT. MUST USE Y570 THERAPY CODE			
694	35	ANESTHETIC MANAGEMENT LIMITED TO ONE METHOD PER PATIENT FOR SAME DATE OF SERVICE			
695	B7	THIS BRATTLEBORO RETREAT # RESTRICTED TO VHAP PCPLUS INPATIENT AGE 18 +			
696	8	THIS DENTAL PROCEDURE CODE DOES NOT ALLOW THE TOOTH NUMBER BILLED			
697	35	DETAIL DIAGNOSIS POINTER MISSING/INVALID OR NO DIAGNOSIS FOR POINTED FIELD			
698	22	THRU DATE OF SERVICE REFLECTS MEDICARE'S COVERED DAYS			
699	17	HOSPITALIZATION STAMP FROM THE DDH IS REQUIRED WITH INPATIENT DENTAL SERVICES			
700	96	VT MEDICAID DOES NOT REIMBURSE FOR CARE OF CORNS AND CALLUSES			
701	16	CLAIM/DETAIL DENIED. PLEASE RESUBMIT WITH ANESTHESIA RECORD(S).			
702	96	THIS SERVICE NOT COVERED FOR PERSONS OVER 21 UNLESS FOR PRESURGICAL DIAGNOSIS			
703	58	THE PLACE OF SERVICE CODE IS INVALID FOR THIS SERVICE.			
704	8	PROCEDURE/REVENUE CODE NOT CONSISTENT WITH PROVIDER TYPE.			
705	B6	PROCEDURE/REVENUE CODE NOT CONSISTENT WITH PROVIDER SPECIALTY.			
706	B22	PROCEDURE CODE/REVENUE CODE/HCCPS CODE NOT CONSISTENT WITH DIAGNOSIS.			
707	B22	PLEASE RESUBMIT WITH A MORE SPECIFIC DIAGNOSIS			
708	B22	E CODES MAY ONLY BE BILLED AS SECONDARY DIAGNOSES			
709	97	POSTPARTUM CARE (59430) INCLUDED IN OTHER PAID/BILLED OB CODE/SERVICE.			
710	125	PLEASE USE APPROPRIATE PROVIDER NUMBER ASSIGNED FOR THIS SERVICE			
711	62	CHIROPRACTIC VISITS (A2000)FOR BENEFICIARIES LESS THAN 12 YRS.OLD REQUIRES PA			
712	58	DOCUMENTATION &/OR RECORDS &/OR RESEARCH INDICATES THE BILLED POS IS INCORRECT.			

713	4	HISTORY AND/OR CLAIM'S DESCRIPTION/NOTES INDICATES MODIFIER IS NEEDED.				
714	125	SAME MD (ATTEND.PROV.#) CANNOT BE BOTH THE SURGEON & THE ASSISTANT SURGEON (80)				
715	125	BOTH THE ANESTHESIOLOGIST & CRNA MUST USE SAME PROCEDURE CODE & APPROP. MODIFIER				
716	47	SERVICE NON-COVERED FOR ADULTS EFFECTIVE 07/29/2002 PER LEGISLATIVE CHANGES				
717	96	VHAP MANAGED CARE NON-COVERED DENTAL BENEFIT. RECIPIENT 18 YEARS OR OVER				
718	35	ADJUSTABLE OSTOMY BELTS (W1547) ARE LIMITED TO 6 PER YEAR (365 DAYS).				
719	47	SERVICE COVERED AS FEE FOR SERVICE - MUST BILL PAPER/TAPE NOT ENCOUNTER CLAIM				
720	17	PHARMACY CLAIM HAS A NEGATIVE UNIT OF SERVICE. RESUBMIT NEW CLAIM.				
721	47	REVENUE CODE NOT CONSISTENT/ALLOWED WITH DIAGNOSIS.				
722	125	PRIMARY DIAGNOSIS FOR A SURGERY CANNOT BE A V-- ("WELL-CARE") DIAGNOSIS CODE.				
723	35	HEALTHY BABIES ASSESSMENT (W0073) IS LIMITED TO TWICE PER PREGNANCY.				
724	35	HEALTHY BABIES ASSESSMENT (W0074) IS LIMITED TO TWICE PER 12 MONTHS (365 DAYS).				
725	2	REBILL MEDICARE USING THE CORRECT HIC NUMBER.				
726	35	HEALTHY BABIES SERVICES W0075 & W0084 ALLOW A MAXIMUM OF 9 VISITS PER PREGNANCY.				
727	35	HEALTHY BABIES SERVICES W0076 & W0084 LIMITED TO A MAX OF 15 VISITS/PREGNANCY.				
728	35	THIS HEALTHY BABIES SERVICE IS LIMITED TO A MAXIMUM OF 10 VISITS PER 12 MONTHS.				
729	35	THIS HEALTHY BABIES SERVICE IS LIMITED TO A MAXIMUM OF 40 VISITS PER YEAR.				
730	35	PSYCHIATRIC DIAGNOSTIC AND EVALUATION INTERVIEWS LIMITED TO 5 UNITS/CALENDAR YR.				
731	35	GROUP PSYCHOTHERAPY (90853 &/OR W9175) LIMITED TO 6 HOURS/WEEK				
732	35	DOH HEALTHY BABIES GROUP EDUCATION (W0082) IS LIMITED TO 6 CLASSES PER 365 DAYS.				
733	16	PLEASE INCLUDE CHARGES FOR OBSERVATION ROOM ON ROOM CHARGE LINE.				
734	47	NEED COMPLETED COPY OF FEDERAL STERILIZATION CONSENT FORM OR HISTORY & OP NOTES.				
735	47	REV. CODE 636 NEEDS HCPCS CODE OR NDC. COVERAGE LTD TO SPECIFIED CONDITIONS/DIAG				
736	96	ELECTRONIC ADJUSTMENT REJECTED - ORIGINAL CLAIM NOT FOUND				
737	22	ELECTRONIC ADJUSTMENT REJECTED - ORIGINAL CLAIM NOT IN A PAID STATUS				
738	97	COST OF ADMINISTERING MEDICINE ALREADY INCLUDED IN PRIMARY CODE.				
739	125	RHC/FQHC SUPPLEMENTAL SERVICE BILLED WITHOUT MC PAYMENT AS OTHER INSURANCE				
740	35	IEP COMPREHENSIVE EVALUATION (X0069) IS LIMITED TO ONCE PER 3 YEARS PER CHILD.				
741	125	TOOTH NUMBER IS INVALID.				
742	35	WEEKLY CASE MANAGEMENT T1016 TL IS LIMITED TO ONE UNIT PER CALENDAR WEEK.				
743	35	WEEKLY MANAGEMENT (X0071) AND 3-YEAR-EVAL (X0069) CANNOT BE PAID IN SAME MONTH.				
744	47	SERVICE NOT COVERED WITHIN SCOPE OF DEPT OF CORRECTIONS PROGRAM				
745	35	CHIROPRACTIC VISITS A2000 AND 98941 ARE LIMITED TO 10 PER CALENDAR YEAR				
746	125	WHEN BILLING Y570 WITH SURGERY, ICD SURGICAL PROCEDURE CODE MUST BE IN FIELD 80.				
747	8	FOR CODES 77420, 77425 & 77430, AS OF DOS 08/01/95, ONE UNIT EQUALS 5 TREATMENTS				
748	125	INCORRECT RECIPIENT NAME ORDER.				
749	A1	SERVICE DENIED BY THE OFFICE OF ORAL HEALTH				

750	35	MAINTENANCE DRUGS REQUIRE A MINIMUM 60 DAY SUPPLY.			
751	8	SEALANTS (D1351 AND D1352) LIMITED TO SURFACES (O,B,L,OB,AND OL) ONLY			
752	35	PERMANENT CROWNS LIMITED TO 1 PER TOOTH EVERY 2 YEARS			
753	35	PULPOTOMY (D3220) LIMITED TO ONCE PER TOOTH PER LIFETIME			
754	35	ROOT CANAL THERAPY LIMITED TO ONE PROCEDURE PER TOOTH PER BENEFICIARY LIFETIME.			
755	2	PLEASE BILL RAILROAD MEDICARE CARRIER.			
756	35	ENDODONTIC IMPLANTS LIMITED TO 1 PER TOOTH PER 2 YEARS			
757	35	D4260,D4270,D4271,&D4280 TOGETHER CANNOT BE BILLED MORE THAN 4 TIMES/LIFETIME			
758	35	SRS TARGETED CASE MANAGEMENT (W0048) IS LIMITED TO ONCE PER CALENDAR MONTH.			
759	B7	AS OF DOS 01/01/03, W1132 & W1133 ARE FOR PARTS ONLY. SEE E1340 FOR LABOR CHARGE			
760	35	PROCEDURE D4340 IS LIMITED TO ONCE PER YEAR, ANY PROVIDER			
761	35	PAYMENT FOR DENTURES (ONE UPPER & ONE LOWER) IS LIMITED TO ONCE PER 5 YEARS.			
762	35	PROCEDURES D5730-D5760 LIMITED TO 1 PER 180 DAYS			
763	35	PROCEDURES D5820-D5840 LIMITED TO 1 PER 365 DAYS			
764	35	EXTRACTIONS LIMITED TO ONCE PER TOOTH PER LIFETIME			
765	35	BITEWINGS ARE LIMITED TO 4 UNITS PER DATE OF SERVICE PER DDH			
766	125	PARTIAL RADIOGRAPHS CANNOT BE BILLED ON SAME DOS AS A COMPLETE SERIES (0210).			
767	35	PROCEDURES D8460-D8580 LIMITED TO 4 UNITS PER LIFETIME			
926	35	DMH EMERGENCY CARE IS LIMITED TO 140 UNITS (35 HOURS) PER WEEK.			
769	42	MENTAL RETARDATION SERVICES ARE LIMITED TO \$200 PER DAY PER CLIENT			
770	125	CHIROPRACTOR CAN ONLY BE ATTENDING ON HCFA WHEN BILLING A2000 - MANIPULATION			
771	35	PREFABRICATED CROWNS LIMITED TO 1 PER TOOTH/2 YEARS, ANY PROVIDER			
772	3	CLAIM PAYMENT REDUCED BY REQUIRED VHAP CO-PAY.			
773	96	DDMHS PARTIAL HOSPITALIZATION NOT ALLOWED SAME DAY AS OTHER DDMHS SERVICES			
774	8	DENTAL PROCEDURES D5212 AND D5214 CANNOT BE BILLED TOGETHER ON THE SAME DATE			
775	125	CHIROPRACTOR CANNOT BE ATTENDING ON UB92 OR PRESCRIBING ON PHARMACY			
776	96	PAYMENT FOR SURGERY INCLUDES RELATED POST-OP VISITS (FED.GLOBAL SURGERY POLICY)			
777	17	DENIED SERVICE, PLEASE SEE HEADER EOB INFORMATION			
778	8	DENTAL PROCEDURES D5730 AND D5750 CANNOT BE BILLED TOGETHER ON THE SAME DATE			
779	125	BOTH THE PANEL AND ITS COMPONENT CODES CANNOT BE BILLED FOR THE SAME DOS.			
780	8	DENTAL PROCEDURES D5740 AND D5760 CANNOT BE BILLED TOGETHER ON THE SAME DATE			
781	62	UNITS BILLED ON CLAIM EXCEED UNITS AUTHORIZED ON PRIOR AUTHORIZATION			
782	16	RECIPIENT ELIGIBLE FOR PHARMACY/CROSS-OVER SERVICES ONLY			
783	35	ENTERAL SUPPLIES (B9998) ARE LIMITED TO A MAXIMUM OF \$220 PER CALENDAR MONTH			
784	96	THIS SERVICE IS NON-COVERED FOR PROGRAM BENEFICIARY IS ENROLLED IN			
785	96	INPATIENT SERVICES NON-COVERED FOR VHAP LIMITED RECIPIENTS.			
786	96	NURSING HOME SERVICES NON-COVERED FOR VHAP LIMITED SERVICES.			

787	96	THIS SERVICE IS NON-COVERED FOR VHAP LIMITED RECIPIENTS.			
788	96	OTC SERVICES NON-COVERED FOR VHAPRX AND VHAP LIMITED RECIPIENTS.			
789	125	CLIENT CANNOT RECEIVE BOTH OUTPATIENT AND RESIDENTIAL TREATMENT ON SAME DOS			
790	35	THIS SERVICE/ITEM LIMITED TO ONCE PER BENEFICIARY LIFETIME.			
791	24	HEALTHY VERMONTERS PHARMACY PROGRAM CLAIM			
792	A1	REFRACTION (92015) NOT COVERED FOR ADULTS PER 2002 LEGISLATIVE MANDATE			
793	16	SAME X-RAY/INTERPRETATION ON SAME DAY REQUIRES DOCUMENTATION OF NECESSITY.			
794	B5	CAST MATERIALS/SUPPLIES ARE LIMITED TO ONE UNIT AND TYPE PER DOS.			
795	96	PAYMENT APPLIED TO VSCRIPT DEDUCTIBLE			
796	B7	PROVIDER TYPE INVALID FOR SUBMISSION OF ENCOUNTER CLAIMS FOR MCO RECIPIENTS.			
797	97	DENIED. SERVICE INCLUDED IN MEDICAID REIMBURSEMENT FOR NURSING HOME STAY.			
798	2	MEDICARE PART B CLAIM RECOUPED DUE TO INCORRECT PROCESSING ERROR.			
799	97	CLAIM/DETAIL DENIED AS INCLUDED WITHIN A PREVIOUS BILLED SERVICE. PLEASE ADJUST.			
800	16	MORE THAN ONE SURGERY, SAME DOS, REQUIRES ADMISSION HISTORY & PROCEDURE/OP NOTE			
801	B20	ANOTHER PROVIDER HAS ALREADY BEEN PAID FOR THE SAME/SIMILAR SERVICE.			
802	35	A MAXIMUM OF FIVE HOME VISITS PER MONTH ARE ALLOWED BY THE SAME PROVIDER			
803	B5	ONLY 5 OFFICE VISITS PER MONTH ARE PERMITTED FOR THE SAME PROVIDER			
804	B5	ONLY ONE HOSPITAL VISIT PER DAY IS ALLOWED FOR SIMILAR OR THE SAME DIAGNOSES			
805	35	NURSING HOME VISITS ARE LIMITED TO FIVE PER MONTH			
806	35	VITAMIN B12 INJECTIONS ARE LIMITED TO ONE PER MONTH			
807	35	LUMBAR-SACRAL ORTHOSES LIMITED TO 2 PER YEAR			
808	59	INJECTIONS SUCH AS 62310-19 & 01996 INCLUDED IN PAYMENT FOR GENERAL ANESTHESIA			
809	42	CARE OF OCULAR PROSTHESIS (V2624) LIMITED TO TWICE PER EYE PER YEAR (365 DAYS).			
810	97	INCLUDED WITHIN OR IDENTICAL TO A CONCURRENTLY BILLED SERVICE.			
811	35	AMBULANCE TRIPS LIMITED TO ONE UNIT PER DAY PER PROVIDER			
812	B5	DDMHS GROUP THERAPY SESSIONS MUST LAST A MINIMUM OF 1 HOUR (UNITS=4)			
813	35	DISCHARGE DAY MANAGEMENT LIMITED TO ONE PER HOSPITAL STAY PER RECIPIENT.			
814	35	CHEMOTHERAPY TREATMENT IS LIMITED TO ONE UNIT PER DAY AND 4 UNITS PER WEEK.			
815	42	DIAGNOSIS AND EVALUATION LIMITED TO 4 HOURS/MONTH OR \$192/MONTH PER RECIPIENT			
816	35	GROUP THERAPY IS LIMITED TO 40 UNITS (10 HOURS) PER WEEK.			
817	35	PSYCHOTHERAPY IS LIMITED TO FIVE HOURS PER WEEK			
818	35	DAY ACTIVITY IS LIMITED TO FIVE PER WEEK.			
819	62	CODE CANNOT BE PAID UNLESS PRIMARY SURGERY IS AUTHORIZED+CODE IS SUBSTANTIATED			
820	8	THIS PSYCHOLOGICAL/PSYCHIATRIC PROC.MAY ONLY BE BILLED IN ONE UNIT OF SERVICE.			
821	42	PSYCHOTHERAPY PYMTS. APPROACHING MAX. ALLOWED. IF EXTENSION NEEDED, APPLY NOW.			
822	17	RECIPIENT CANNOT BE CLASSIFIED AS BOTH MH AND MR/DD FOR THE SAME DATE OF SERVICE			
823	35	MAXIMUM OF \$500 PER YEAR LIMIT HAS BEEN REACHED.			

824	35	PSYCHOLOGICAL TESTING (90830/96100) IS LIMITED TO 5 HOURS PER YEAR (365 DAYS).				
825	42	PAYMENT REDUCED TO MAXIMUM ALLOWED FOR TOTAL OB CARE.				
826	42	ADULT DENTAL BENEFITS APPROACHING MAXIMUM ALLOWED AMOUNT FOR THIS PATIENT				
827	35	ADULT DENTAL'S MAXIMUM ALLOWED AMOUNT HAS BEEN REACHED FOR THIS RECIPIENT				
828	35	PROCEDURES W9184 AND 90830 LIMITED TO 5 HOURS A YEAR.				
829	B13	TOTAL OB CARE CANNOT BE BILLED BECAUSE PRENATAL VISITS ALREADY PAID.				
830	B5	PRENATAL VISITS AND TOTAL OB CARE CANNOT BE BILLED FOR THE SAME PREGNANCY				
831	B13	TOTAL OB CARE CANNOT BE PAID BECAUSE PARTIAL OB CARE ALREADY PAID				
832	125	SECOND,ETC.CONSULT FOR RELATED CONDITIONS SHOULD BE BILLED WITH "FOLLOW-UP" CODE				
833	17	AMBULANCE CERTIFICATION FORM MISSING				
834	125	AN MD PROVIDING ACTUAL TREATMENT CANNOT ALSO BILL AS A CONSULTANT				
835	16	PLEASE RESUBMIT WITH NOTES INDICATING DATE AND PROVIDER OF ORIGINAL SURGERY				
836	97	POST-OP CARE IS INCLUDED WITHIN THE SURGICAL SERVICE REIMBURSEMENT				
837	125	NEW PATIENT PROCEDURE CODES ARE NOT ALLOWED FOR ESTABLISHED PATIENTS.				
838	125	ROUTINE MAMMOGRAPHY SCREENING (76092) FOR BCCT CLIENT WAS PAID BY DOH				
839	125	SUBSEQUENT CONSULT FOR RELATED CONDITION: USE ESTAB.PATIENT MEDICAL CODE				
840	16	PLEASE RESUBMIT WITH COPIES OF THE APPROPRIATE INITIAL CONSULTATION RECORDS				
841	97	CAST APPLICATION INCLUDED IN PRICE PAID FOR FRACTURE WITH REDUCTION FOR 30 DAYS				
842	125	OBSERVATION ROOM VISITS AND ER VISITS CANNOT BOTH BE BILLED FOR THE SAME DOS.				
843	35	PRENATAL VISITS LIMITED TO 15 PER YEAR				
844	35	INITIAL CONSULTS ARE LIMITED TO ONE PER PATIENT FOR SIMILAR DIAGNOSES				
845	97	THESE SERVICES INCLUDED IN PREVIOUSLY PAID ECG WITH STRESS TESTING				
846	62	MORE THAN 1 ADMISSION TO SAME FACILITY WITHIN 30 DAYS NEEDS REVIEW OF ADMISSION HIST				
847	35	WEEKLY RADIATION THERAPY MANAGEMENT (77420-77430) IS LIMITED TO 5 UNITS PER WEEK				
848	35	ADMISSION CODES LIMITED TO ONE PER HOSPITAL PER 30 DAYS FOR SIMILAR DIAGNOSES				
849	35	PA REQUIRED FOR MORE THAN TWO CONTACT LENSES PER LIFETIME				
850	35	ONE INTRAOCULAR LENS ALLOWED PER LIFETIME.				
851	35	THE MAXIMUM UNITS FOR REHAB EVALUATIVE SERVICES HAS BEEN MET FOR CALENDAR YEAR				
852	125	GASTROSTOMY JEJUNOSTOMY TUBES B4086 ARE LIMITED TO TWO PER 6 MONTHS				
853	35	SKILLED NURSING AND INTERMEDIATE CARE FACILITY VISITS ARE LIMITED TO ONE/WEEK				
854	35	PRENATAL VISITS LIMITED TO 15/YEAR FOR NURSE MIDWIVES				
855	125	INDIVIDUAL SERVICES AND WAIVER CANNOT BE BILLED FOR OVERLAPPING DATES				
856	125	FOR 2ND ADMIT/MONTH/SIMILAR DIAGNOSIS,USE SUBSEQUENT HOSP.CARE CODE(99231-99233)				
857	49	SERVICE INCLUDED WITHIN ROUTINE NEWBORN CARE (99431).				
858	125	PROCEDURE CODES W1000 AND A9030 CANNOT BE BILLED ON THE SAME DATE OF SERVICE				
859	35	ROUTINE NEWBORN CARE LIMITED TO 1 PER DELIVERY				
860	35	NEWBORN RESUSCITATION LIMITED TO ONE PER DELIVERY				

861	47	THIS HUD/HHS IS NO LONGER A COVERED SERVICE				
862	35	DENTURE ADJUSTMENTS ARE LIMITED TO ONCE PER DENTURE WITHIN 180 DAYS.				
863	42	DAILY ESRD-RELATED SERVICES CANNOT PAY MORE PER CALENDAR MONTH THAN MONTHLY SV				
864	16	PLEASE RESUBMIT WITH COPIES OF ALL ADMISSION HISTORIES WITHIN 30 DAYS.				
865	B14	ONLY ONE OFFICE/EPSTDT VISIT PERMITTED PER DAY FOR SAME RECIPIENT, SAME PROVIDER				
866	35	PAYMENT HAS BEEN MADE FOR MAXIMUM # ALLOWED. OVHA AUTHORIZATION NEEDED FOR MOR				
867	35	HEMODIALYSIS CODES 90935 AND/OR 90937 LIMITED TO 3 UNITS WITHIN 7 DAYS.				
868	8	P.A. APPROVED FOR PURCHASE NOT RENTAL, REBILL WITHOUT MODIFIERS.				
869	35	DDMHS "PARTIAL HOSPITALIZATION" (Z--50) IS LIMITED TO ONE PER DATE OF SERVICE.				
870	35	MAXIMUM # OF ALLOWED UNITS HAS BEEN MET (W9173 LTD TO 60 UNITS/CALENDAR YEAR)				
871	125	ALLERGY VACCINES MAY ONLY BE BILLED IN ONE UNIT PER DATE OF SERVICE				
872	125	OSTEOPATHIC MANIPULATIVE TREATMENT CANNOT BE BILLED IN ADDITION TO MEDICAL VISIT				
873	17	INFORMATION ON ATTACHMENT IS OUTDATED. RESUBMIT WITH CURRENT INFORMATION.				
874	35	REFILL TOO SOON.				
875	57	PAYMENT REDUCED TO PSYCHOTHERAPY LIMITATION OF 8 UNITS PER DAY				
876	125	CANNOT BILL NORMAL NEWBORN ADMIT AND SUBSEQUENT HOSPITAL VISITS FOR SAME STAY				
877	35	PROCEDURE CODES X2800-X2809 LIMITED TO TWO UNITS PER DAY				
878	35	GENERAL PSYCHOTHERAPY IS LIMITED TO 8 UNITS PER DAY.				
879	35	DMH GENERAL PSYCHOTHERAPY (X2871,ETC.AND X4871,ETC.) LIMITED TO 28 UNITS/WEEK				
880	35	CONSULTATIONS LIMITED TO ONE UNIT PER DOS				
881	35	MH/REHAB DIAG.+EVAL. LIMITED TO 120 UNITS (30 HOURS) PER CALENDAR YEAR				
882	35	DMH DAY HOSPITAL (X2876,X2876FB AND X2876TF) LIMITED TO ONE UNIT PER DAY				
883	35	MH DAY TREATMENT (Z1035, Z2035, Z3035, Z5035) IS LIMITED TO ONE UNIT PER DAY				
884	35	SERVICE NOT COVERED FOR CLIENT 21+ - CERTIFIED ADAP ADOLESCENT COUNSELOR				
885	35	MR MILEAGE (X3800-X3810) LIMITED TO 2 UNITS PER DAY				
886	35	WHEELCHAIR REPAIRS INCLUDED IN WARRANTY FOR FIRST 12 MONTHS. CLAIM DENIED.				
887	35	ECHOCARDIOGRAPHY LIMITED TO ONE PER DATE OF SERVICE.				
888	35	MR/REHAB GENERAL PSYCHOTHERAPY IS LIMITED TO 28 UNITS (7 HOURS) PER WEEK				
889	35	OFF-THE-SHELF SPLINTS ARE TO BE BILLED WITH PROCEDURE CODE A4570 AND AN INVOICE.				
890	35	MR/REHAB DIAGNOSIS&EVAL.IS LIMITED TO 120 UNITS (30 HOURS) PER YEAR				
891	35	OADAP DIAGNOSIS AND EVALUATION (X9004) LIMITED TO 20 UNITS (5HRS) PER 365 DAYS				
892	B19	PHARMACIST INTERVENTION DENIED BY CONSULTANT REVIEW.				
893	B3	SPAN OF DAYS FOR MILEAGE DOES NOT EQUAL DATES OF CLINIC VISITS.				
894	35	VHAP RX BENEFICIARIES REQUIRE REFRACTION CODE 92015 SAME DAY AS E & M				
895	35	ADAP SUBSTANCE ABUSE CASE MANAGEMENT (H0006) LTD.TO 30 HRS (120 UNITS)/CAL.YEAR				
896	35	WAIVER SERVICES LIMITED TO ONE UNIT PER DOS				
897	35	THE MAXIMUM LABOR TIME ALLOWED FOR SEATING SYSTEMS IS 5 HOURS (20 UNITS)				

898	35	THE MAXIMUM LABOR TIME ALLOWED FOR SEATING SYSTEM MODIFICATIONS IS 3 HOURS (12U)			
899	35	DDMHS ADAP SERVICES Z0700, Z0737 & Z0738 ARE LIMITED TO 40 UNITS (10 HRS) PER WK			
900	35	ROUTINE VENIPUNCTURE FOR SPECIMEN(S) COLLECTION LIMITED TO 1 UNIT/DAY/PROVIDER			
901	63	CAPITATION CLAIM RECOUPED PER OVHA- RECIPIENT NOT ENROLLED IN MCO.			
902	35	ANNUAL PCP PAYMENT (Y0069) IS LIMITED TO ONCE PER CALENDAR YR/PRIMARY PROVIDER			
903	57	THE AMOUNT OF MEDICATION BEING BILLED EXCEEDS AMOUNT ORDERED BY PHYSICIAN.			
904	24	ZERO PAID CLAIMS - DENTAL CLINIC PROCESSING.			
905	35	OVHA PAYMENT FOR GLUCOMETERS IS LIMITED TO ONE PER PATIENT PER 5 YEARS.			
906	8	WAIVER CODES X8100-X8122 CANNOT BE BILLED WITH PROCEDURE CODES X3800-X3888			
907	8	ITEM IS NOT USUAL/CUSTOMARY FOR DIAGNOSIS/CONDITION INDICATED. PLEASE EXPLAIN.			
908	8	NDC/MEDICATION BILLED DOES NOT MATCH MEDICATION/DESCRIPTION ON MD'S ORDER			
909	97	THE MOTHER'S ADMISSION IS INCLUDED WITHIN THE OB/DELIVERY REIMBURSEMENT			
910	35	VISUAL ANALYSIS AND INTERIM VISIT LIMITED TO ONE PER TWO YEARS			
911	8	OPHTHALMOLOGICAL SERVICES (92012/92014) LIMITED TO 1 YEAR/RECIPIENT FOR THIS PT			
912	16	MOST FRACTURES HEAL IN 6-8 WEEKS. WHY IS THIRD MONTH RENTAL MEDICALLY NECESSARY?			
913	35	REFRACTION IS LIMITED TO ONCE IN TWO YEARS.			
914	35	THE MAXIMUM ALLOWED OF 3 ROOT CANALS PER ADULT RECIPIENT LIFETIME HAS BEEN MET			
915	8	MISSING/INVALID NCPDP DATA ELEMENT			
916	35	DMH/MR SPECIAL.GROUP REHAB LTD.TO 8 UNITS OR 2 HRS PER DOS			
917	35	AS OF 1/1/96, DMH/MR SPECIAL.GROUP REHAB (Z**38) LTD.TO 40 UNITS (10 HRS)/CAL.WK			
918	35	AMBULATORY SURGICAL CENTER FACILITY FEES ARE LIMITED TO ONE PER DOS.			
919	8	AMBULATORY SURGICAL CENTERS: BILL MODIFIER SG ON YOUR PRIMARY SURGICAL PROC CODE			
920	8	PROPHY.(01110, 01120) & FULL MOUTH DEBRIDEMENT (04355) CANNOT BE PAID SAME DOS.			
921	16	RESUBMIT WITH SPECIFIC INFORMATION ON PATIENT'S FUNCTIONAL LIMITATIONS			
922	16	NEED DOCUMENTATION THAT USE OF A LESS EXPENSIVE ITEM WAS NOT ADEQUATE.			
923	B1	CLAIM RECOUPED PER REQUEST OF OVHA/PRO, DUE TO NON-MEDICALLY NECESSARY DAYS.			
924	63	THIS CLAIM HAS BEEN RECOUPED. YOU MAY NOW SUBMIT A NEW CLAIM WITH MEDICARE EOMB			
925	35	DMH EMERGENCY CARE IS LIMITED TO 28 UNITS (7 HOURS) PER DAY.			
1013	142	TBI SERVICE REDUCED BY PATIENT SHARE AMOUNT			
927	16	RESUBMIT WITH ALL ATTACHMENTS REQUIRED FOR MANUAL PRICING.			
928	35	RURAL HEALTH CLINIC (W1040) AND FQHC (W1050) ENCOUNTERS LIMITED TO 5 PER MONTH			
929	35	Z5036 IS LIMITED TO 20 UNITS (5 HOURS) PER DAY & 100 UNITS (25 HOURS) PER WEEK.			
930	17	RESUBMIT WITH EXPLANATION OF CONTINUED USE PAST USUAL LENGTH OF NEED			
931	35	ORAL HYGIENE INSTRUCTIONS (01330) ARE LIMITED TO ONCE PER YEAR (365 DAYS)			
932	35	CEPHALOMETRIC X-RAY (00340) IS LIMITED TO ONCE IN TWO YEARS.			
933	35	DIAGNOSTIC MODELS (00470) ARE LIMITED TO ONE PER TWO YEARS.			
934	35	DIAGNOSTIC PHOTOGRAPHS (00471) LIMITED TO ONCE IN TWO YEARS.			

935	35	FULL MOUTH DEBRIDEMENT (D4355) IS LIMITED TO ONCE IN TWO YEARS (730 DAYS).			
936	35	FLUORIDE TREATMENT (01203) IS LIMITED TO ONCE PER PATIENT PER 6 MONTHS.			
937	97	IV FLUIDS USED TO MIX/ADMINISTER/FLUSH MEDS ARE INCLUDED IN IV INFUSION TX CODES			
938	35	TMJ SPLINT (D7880) LIMITED TO ONE PER JOINT IN TWO YEARS.			
939	96	MILEAGE IS COVERED ONLY WHEN CLINIC,CASE MANAGEMENT OR REHAB SVCS.ARE PROVIDED			
940	35	INITIAL ORAL EXAM (D0110/D0150) LIMITED TO 1 PER SAME PROVIDER, PER PAT.LIFETIME			
941	35	PERIODIC ORAL EXAM (PROCEDURE D0120) LIMITED TO ONE PER SIX MONTHS.			
942	35	ONLY ONE ORAL EXAM (INITIAL AND/OR PERIODIC) IS COVERED PER 6 MONTHS			
943	35	COMPLETE SERIES RADIOGRAPHS (0210) LIMITED TO ONCE IN TWO YEARS.			
944	35	INTRAORAL FILMS (00220 AND 00230) ARE LIMITED TO A MAX OF \$55 PER DOS, PER PROV.			
945	94	BILLED AMOUNT ON CLAIM DOES NOT MATCH THE DOLLAR AMOUNT YOU REQUESTED ON YOUR F			
946	35	BILL DME SUPPLY CODES ONLY ONCE PER CALENDAR MONTH FOR TOTAL NUMBER OF UNITS.			
947	35	PANORAMIC FILM D0330 LIMITED TO 1 PER 2 YEARS			
948	35	DENTAL PROPHYLAXIS (D1110, D1120, D4910) LIMITED TO 1 PER 6 MONTHS (180 DAYS)			
949	35	PIN FOR RESTORATION (D2951) LIMITED TO ONE/TOOTH/YEAR,ANY PROVIDER			
950	108	DME CANNOT BE RENTED FOR LONGER THAN 3 MONTHS UNLESS APPROVAL GIVEN BY THE OVHA			
951	16	BOTH THE DATE OF PRESCRIPTION AND THE DATE OF PROVIDER'S SIGN.NEEDED TO PROCESS.			
952	17	PLEASE RESUBMIT ON DME/SUPPLIES CLAIM FORM			
953	35	DENTURE REPAIRS ARE LIMITED TO ONCE PER DENTURE PER 180 DAYS.			
954	35	DENTAL TISSUE CONDITIONING IS LIMITED TO ONCE PER DENTURE IN 2 YEARS (730 DAYS).			
955	35	RESTORATIVE TREATMENT LIMITED TO ONCE PER TOOTH/TOOTH SURFACE PER YEAR.			
956	B22	DIAGNOSES DO NOT JUSTIFY ITEM/SERVICE PROVIDED AND/OR FUNCTIONAL LEVEL.			
957	97	DENIED.FIRST MONTH'S 'TENS' SUPPLIES INCLUDED IN RENTAL FEE FOR E0730-RR.			
958	17	RESUBMIT WITH DATE ITEM PURCHASED (OR RENTAL START DATE) AND PROVIDER OF ITEM.			
959	62	ENTERAL SUPPLIES ARE LIMITED TO HIGH TECH PROVIDERS,WITH PA FROM MEDICAID			
960	17	RESUBMIT WITH YOUR LABOR RATE (PER HOUR) AND THE TOTAL TIME BEING BILLED.			
961	16	PLEASE RESUBMIT UNITS SHOULD EQUAL NO. OF TOTAL ITEMS IN ALL INDIVIDUAL PACKAGES			
962	62	OVHA AUTHORIZATION REQUIRED WHEN SERVICE PROVIDED TO BENEFICIARY UNDER AGE 18			
963	16	ITEMIZE CHARGES FOR INDIVIDUAL ITEMS: NAME, COST OF EACH AND NUMBER SUPPLIED.			
964	17	RESUBMIT WITH INVOICE AND COPY OF WARRENTEE			
965	125	INAPPROPRIATE CODE. PLEASE REFER TO YOUR HCPCS MANUAL.			
966	62	SERVICE DATE IS BEFORE AUTHORIZED DATE IN PA NUMBER.			
967	62	BILLED UNITS MUST = CHARTED TIME ONLY. 1U=15MINS. DO NOT INCLUDE THE BASE UNITS.			
968	50	MEDICAL NECESSITY FORM DOES NOT DOCUMENT NEED OF ITEM			
969	B5	QUANTITY PROVIDED MONTHLY EXCEEDS NORMAL USAGE			
970	16	PLEASE GIVE ITEMIZED LIST OF LABOR AND/OR PARTS CHARGES			
971	97	THESE SUPPLIES ARE INCLUDED WITHIN THE REIMBURSEMENT OF THE EQUIPMENT RENTAL.			

972	16	WHEELCHAIR PRICING REQUIRES BRAND NAME AND MODEL NUMBER			
973	16	LENGTH OF NEED INDICATED ON THE MED.NECESSITY FORM CONTRADICTS BILLING RENTAL.			
974	17	COMPLETE MED SUPPLIES SECTION OF MED. NEC. FORM AND INDICATE AVG. MONTHLY USAGE.			
975	16	PLEASE RESUBMIT WITH MANUFACTUROR'S INVOICE OR SUGGESTED LIST PRICE			
976	B5	QUANTITY PROVIDED EXCEEDS ALLOWED/NORMAL AMOUNTS.			
977	17	THE DATE THAT THE PHYSICIAN'S CERTIFICATION WAS COMPLETED IS ILLEGIBLE/INVALID.			
978	108	INDICATED LONG TERM NEED (PER DIAGNOSIS OR >3 MOS) CONTRADICTS BILLING OF RENTAL			
979	94	QUANTITY/UNITS BILLED EXCEED(S) AMOUNT APPROVED ON MEDICAL NECESSITY FORM			
980	62	P.A. OR EXPLANATION REQUIRED TO JUSTIFY EXCESSIVE QUANTITIES/UNITS.			
981	108	DOCUMENTATION INDICATES TEMPORARY NEED. REBILL FOR RENTAL INSTEAD OF PURCHASE.			
982	35	PERIODIC (ANNUAL) EXAM LIMITED TO ONCE PER YEAR.			
983	96	SERVICE COVERED UNDER SOLE-SOURCE RESPIRATORY CONTRACT THROUGH DOS 06/30/01.			
984	96	ONLY SOLE-SOURCE CONTRACTOR ALLOWED OXYGEN IN NURSING HOME (POS 31,32 & 33)			
985	17	ATTACHED RX IS INCOMPLETE AND/OR DOES NOT COVER SOME OR ALL BILLED DATES			
986	35	DENTAL SEALANTS (D1351 & D1352) LTD.TO ONCE/TOOTH PER FIVE YEARS, ANY PROVIDER.			
987	16	Y9873 NEEDS MD PRESCRIPTION (DOSAGE, FREQ., DURATION) AND NATIONAL DRUG CODE #			
988	16	EXPLANATION/DOCUMENTATION NEEDED TO JUSTIFY MORE EXPENSIVE ITEM			
989	8	THERAPEUTIC FOSTER CARE (-TF) AND FAMILY BASED (-FB) SERVICES ARE EXCLUSIVE			
990	17	DOCUMENTATION DOES NOT JUSTIFY NEED FOR STERILE ITEM(S)			
991	16	SPECIFIC INFORMATION NEEDED TO EXPLAIN WHAT THE BILLED ITEM IS BEING USED FOR.			
992	63	CLAIM RECOUPED. EDS WILL RESUBMIT NEW CLAIM WITH ORIGINAL EOMB AND ADJTM EOMB.			
993	63	CLAIM RECOUPED. RESUBMIT NEW CLAIM WITH ORIGINAL EOMB AND MEDICARE ADJMT EOMB.			
994	63	AS REQUESTED THIS CLAIM HAS BEEN RECOUPED AND YOU MAY NOW RESUBMIT A NEW CLAIM.			
995	63	THIS CLAIM HAS BEEN RECOUPED PER PROV. NEW CLAIM HAS BEEN SUBMITTED FOR PROCESS			
996	63	THIS CLAIM IS RECOUPED BECAUSE OF PROCESSING ERROR; CLAIM WAS RESUBMITTED BY EDS			
997	63	WE HAVE SPLIT AND REBATCHED YOUR CLAIM. IT WILL SHOW AS PENDING ON YOUR NEXT RA.			
998	63	THIS CLAIM WAS RECOUPED DUE TO AN ADJUSTMENT REQUEST SUBMITTED BY EDS/OVHA			
999	63	THIS CLAIM HAS BEEN RECOUPED DUE TO AN ADJUSTMENT REQUEST SUBMITTED BY PROVIDER.			
1050	125	PROCEDURE CODE 80101 CANNOT BE BILLED SAME DAY/SAME PROVIDER AS 82570/83986			
1020	96	THE LADIES FIRST PROGRAM DOES NOT COVER MALE BENEFICIARIES			
1022	96	LADIES FIRST SERVICE COVERED FOR AGE 40 AND OVER ONLY			
1033	95	SPLIT CLAIM INTO SINGLE DETAIL CLAIMS WITH CORRECT OTHER INSURANCE FOR EACH DETAIL			
1026	96	THIS REVENUE CODE IS NOT COVERED FOR THE LADIES FIRST PROGRAM			
1027	96	EITHER THE BILLING OR ATTENDING PROVIDER IS NOT ENROLLED IN THE LADIES FIRST PROGRAM			
1021	96	LADIES FIRST PROGRAM DOES NOT COVER THIS DIAGNOSIS CODE			
1028	96	THIS CLAIM TYPE IS NOT COVERED BY THE LADIES FIRST PROGRAM			
1032	96	THIS REVENUE CODE REQUIRES A HCPCS/CPT CODE FOR THE LADIES FIRST PROGRAM			

1034	96	EITHER THE BILLING PROVIDER OR THE CLIENT IS NOT COVERED BY LADIES FIRST PROGRAM			
1029	96	THIS LADIES FIRST PROGRAM REQUIRES A VOUCHER FOR THIS SERVICE			
1055	96	THIS SERVICE IS NOT VALID FOR THE DATE OF SERVICE BILLED			
1000	125	OCCURRENCE/ACCIDENT DATE IS AFTER THE FROM DATE OF SERVICE			
1036	96	THIS LADIES FIRST DIAGNOSIS CODE IS BILLABLE ONLY FOR WOMEN AGE 40 AND OLDER			
1051	125	THE INFORMATION ON THE ATTACHED RA DOES NOT MATCH THE INFORMATION ON THE CLAIM			
1037	95	THIS CLAIM TYPE REQUIRES OTHER INSURANCE PAYMENT SUBMITTED AT DETAIL LEVEL			
1049	96	VT MEDICAID DOES NOT COVER THIS SERVICE WHEN BILLED ON AN OUTPATIENT CLAIM			
1066	40	ONE OF THE DIAGNOSIS CODES POINTED TO IS NOT VALID PER ICD 9 LISTING			
1089	125	A CPT CODE IS REQUIRED AT DETAIL WHEN REVENUE CODE 360, 361, 362, 367 OR 490 IS BILLED			
1040	29	RA INVALID DOCUMENTATION FOR TIMELY FILING. PREVIOUS DENIAL WAS FOR TIMELY FILING.			
1056	16	THIS MODIFIER IS NOT VALID FOR THE DOS BILLED			
1099	96	CLAIM DENIED WHILE WAITING PRICING FROM OVHA			
1012	125	THIS CLAIM HAS BEEN RECOUPED AS THE RESULT OF AN ADJUSTMENT REQUEST			
1042	16	THIS SERVICE REQUIRES AN ITEMIZED BILL SENT TO LADIES FIRST AT DEPT OF HEALTH			
1043	16	SEND A CLINICAL REPORT TO LADIES FIRST AT DOH FOR REVIEW PRIOR TO PAYMENT			
1057	16	YOUR ELECTRONIC CERT FORM IS MISSING INFORMATION			
1045	16	SEND CLINICAL REPORT TO LF AT DOH TO CLARIFY SERVICES AS MULTIPLE ICD 9 CODES WERE U			
1058	35	90846 IS LIMITED TO 12 PER YEAR. PA FROM OVHA IS REQUIRED FOR ADDITIONAL SERVICES			
1059	62	DATE OF SERVICE ON THE CLAIM DOESN'T MATCH THE DATE OF SERVICE ON THE VOUCHER			
1060	62	PROVIDER NUMBER ON YOUR CLAIM DOESN'T MATCH THE PROVIDER NUMBER ON THE VOUCHER			
8109	16	PROCEDURE DOES NOT WARRANT ASSISTANT SURGEON			
8111	97	PROCEDURE IS INCIDENTAL TO ANOTHER SUBMITTED PROCEDURE			
8112	97	PRE-OPERATIVE SERVICE NOT PAID DURING GLOBAL PERIOD			
8113	97	POST-OPERATIVE SERVICE NOT PAID DURING GLOBAL PERIOD			
8110	54	PROCEDURE DOES NOT WARRANT ASSISTANT SURGEON			
1044	A1	THIS PROGRAM COVERS PART B DRUGS AND DIABETIC SUPPLIES ONLY ON THIS CLAIM TYPE			
1052	16	RESUBMIT YOUR CLAIM WITH A COPY OF THE ORIGINAL RA THAT SHOWS PROOF OF TIMELY FILIN			
1067	16	THE FIELD 24E ONLY ACCEPTS DIAGNOSIS POINTERS 1,2,3 OR 4 NOT THE ACTUAL DIAGNOSIS COL			
1068	16	ONE OF THE DIAGNOSIS BILLED IS NOT CONSISTENT WITH THE RECIPIENTS AGE			
1039	119	THIS PROVIDER'S MODERATE CARE ANNUAL CAP PAYMENT HAS BEEN MET			
1061	147	THERE IS NO ANNUAL WAIVER MODERATE CAP AMOUNT ON FILE FOR THIS PROVIDER			
1038	42	PAYMENT REDUCED TO PROVIDER MODERATE CAP BALANCE			
1041	96	SERVICES FOR MODERATE INDIVIDUALS ARE LIMITED TO REV CODE 070, 095, AND 096			
1053	96	THIS SERVICE IS NOT COVERED FOR THE PROGRAM THAT THE CLIENT IS ENROLLED IN			
1046	96	CASE MANAGEMENT BY HHA IS LIMITED TO 12 HOURS PER YEAR FOR MODERATE LEVEL RECIPIEN			
1047	96	MODERATE SVCS FOR REV CODE 095 ARE LIMITED TO 26 HOURS PER MONTH			

1048	96	MODERATE SVCS FOR REV CODE 096 ARE LIMITED TO 130 HOURS/MONTH			
1100	38	NO RECIPIENT RATE ON FILE			
1062	16	PLEASE INDICATE NURSING HOME NAME IN THE REMARKS FIELD			
1001	B6	COPAY REIMBURSED FOR CAPITATED SERVICES ONLY			
1085	96	CLAIM DENIED AS THE CLIENT HAS NO AUTHORIZATION FOR THIS WAIVER SERVICE.			
1063	4	MODIFIER NOT ACCEPTED AT THIS TIME. ALL MODIFERS ARE UNDER REVIEW BY OVHA.			
1064	29	ONLY THE RA WITH PAID OR DENIED CLAIMS ARE ACCEPTABLE AS PROOF OF TIMELY FILING			
1088	52	VERIFY RPL. OUR FILES SHOW HCBS SERVICES AUTHORIZED NOT NURSING HOME			
1069	16	PLEASE UNDERLINE OR CIRCLE ON ATTACHMENTS, DO NOT HIGHLIGHT			
1018	B7	BILLING PROVIDER NUMBER IS NOT CORRECT FOR UB92 LF FACILITY SERVICE			
1019	B7	BILLING PROVIDER NUMBER IS NOT CORRECT FOR HCFA LF NON-FACILITY SERVICE			
1120	97	CLAIM PAYMENT REDUCED, DOLLARS ARE INCLUDED IN THE CASE RATE			
1017	A1	MAKE CORRECTIONS BASED ON HEADER OR DETAIL EOB DENIALS AND RESUBMIT NEW CLAIM			
1065	29	REQUEST FOR OVERRIDE OF TWO YEAR TIMELY FILING HAS BEEN DENIED BY OVHA			
1122	119	CLAIM PAYMENT REDUCED TO RECIPIENTS FLEXIBLE CHOICES QUARTERLY ALLOTMENT AMT			
1130	42	THE COINSURANCE AND DEDUCTIBLE AMOUNTS CANNOT BE GREATER THAN YOUR BILLED AMOUNT			
1070	125	METHADONE TREATMENT LIMITED TO 1 PER CALENDAR WEEK			
1121	96	THIS SERVICE IS NOT COVERED FOR THE CASH AND COUNSELING PROGRAM			
1123	46	REV CODE 071 LIMITED TO HCPCS T2025, S5121, AND S5199 FOR CASH AND COUNSELING PROGRAM			
1124	119	RECIPIENT'S FLEXIBLE CHOICES QUARTERLY ALLOTMENT AMOUNT HAS BEEN MET			
1125	119	VHAP BENEFICIARY HAS ALREADY BEEN PAID FOR 30 DAYS OF NH SERVICES FOR THIS CALENDAR			
1071	47	ONE OF THE DIAGNOSIS CODES POINTED TO IS MISSING			
1146	96	THIS PROGRAM COVERS DIABETIC SUPPLIES, J CODES FOR MAINTENANCE DRUG COINS/DED ONLY			
1072	16	PROCEDURE DENIED AS COSMETIC. RESUBMIT WITH DOCUMENTATION PROVING MEDICAL NECESSITY			
1073	18	THIS SERVICE HAS ALREADY BEEN FORWARDED TO ADMINISTRATIVE SERVICES FOR PAYMENT			
1074	96	THIS CLIENT CANNOT HAVE BOTH HCBS AND FLEXIBLE CHOICES SERVICES ON THE SAME DATE			
1131	17	OCCURRENCE CODE BILLED IS NOT VALID FOR REHABILITATIVE THERAPY SUBMITTED			
1132	17	OCCURRENCE CODE AND THERAPY START DATE MUST BE BILLED WHEN SERVICE IS REHABILITATIVE			
1133	18	OUR HISTORY FILES SHOW THIS SERVICE HAS BEEN REIMBURSED BY MEDMETRICS			
1002	42	MANUALLY PRICED UP TO THE ALLOWED NUMBER OF UNITS			
1003	141	HOSPICE INPATIENT SERVICES EXCEED INPATIENT STAY			
1004	97	A PORTION OF THIS CLAIM WAS PAID AS A HOSPICE CLAIM			
1005	4	RESUBMIT WITHOUT A MODIFIER 76/77 AND WITH NOTES OF EXPLANATION			
1006	16	SPLIT THE CLAIM ACCORDING TO AUTHORIZATION FOR HCBS OR ERC AND NURSING HOME			
1007	16	THIS ADJUSTMENT IS A RESULT OF POST PAYMENT REVIEW DONE BY SUR UNIT			
1008	A1	SERVICES NOT COVERED BY MEDICAID. RECIPIENT PARTICIPATING IN PACE			
1010	150	MORE THAN ONE TIER FOR SAME OR OVERLAPPING DOS NOT ALLOWED FOR ERC.			

1009	97	CLAIM ADJUSTED/CUTBACK DUE TO MULTIPLE SURGERY POLICY
1011	16	ATTACHED RA IS NOT LEGIBILE
1075	31	PLEASE VERIFY BENEFICIARY SOCIAL SECURITY NUMBER - NUMBER NOT ON FILE WITH LADIES FI
1076	29	ELEC ADJUSTMENT NOT ALLOWED. NOT ALL DETAILS MEET TIMELY FILING POLICY
1147	16	RECIPIENT HAS MEDICARE PART C. PLEASE BILL THEIR SELECTED CARRIER
1101	133	CLAIM FORWARDED TO THE OOH FOR REVIEW. PRICING AND PMT BY ADMIN SVCS.
1103	108	SPOT CHECK OXIMETER RENTAL LTD TO 3 MO/LIFETIME
1104	108	CONT. W/24HR TRENDING OXIMETER RENTAL LTD 6MO/LIFE
1105	133	THERE IS NO VALID GA VOUCHER FOR THIS SERVICE
1014	125	HPV VACCINE LTD TO 3 PER PATIENT PER LIFETIME
1016	125	AS OF 1/1/07 WHEN BILLING 3 FILMS APPROPRIATE CODE IS D0273
1078	B7	REFERRING PHYSICIAN NUMBER IS MISSING OR NOT VALID FOR INDEPENDENT LAB SERVICE
1150	108	OXIMETER PURCHASE LTD TO 1 PER 3 YEARS PER BENEFICIARY
1024	B5	HOME VISITS LIMITED TO 5 PER MONTH
1054	125	THIS REVENUE CODE REQUIRES A HCPCS CODE
1077	140	RECIPIENT NAME/NUMBER IS INCORRECT OR MISSING
1035	A1	MUST BE BILLED AS MDC TO PHARMACY
1079	B5	ORAL HYGIENE INSTRUCTIONS D1330 CANNOT BE BILLED ON SAME DOS AS D0145
1080	B5	D0220 ALLOWED ONLY ONCE PER DOS, ANY TOOTH

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