Claim Denial Codes List

as of 03/01/2021

Claim Adjustment Reason Code (CARC)		Remittance Advice Remark Code (RARC)			CORE Business Scenario
Code	Description	Code	Description	Medicaid Denial Reason	
4	The procedure code is inconsistent with the modifier used.			UC Modifier/Condition Code missing	2
				Invalid pickup location modifier.	2
				Invalid destination modifier.	2
				Modifier not authorized for claim type.	2
				U Modifier is missing or invalid for particular waiver program.	2
				Missing or invalid modifier	2
4	The procedure code is inconsistent with the modifier used.	N519	Invalid combination of HCPCS modifiers.	Invalid Procedure to modifier	2
				Invalid modifier for procedure code. See provider manual, section 2 for modifier requirements.	2
				Invalid modifier for transport	2
				Procedure requires modifier. Please rebill with correct information.	2
				Missing destination modifier	2
5	The procedure code/type of bill is inconsistent with the place of service.			History procedure incidental to other current procedure.	3
				Service not covered by Medicaid when service provided in outpatient - was for routine care.	3
				Invalid bill type	3
5	The procedure code/type of bill is inconsistent with the place of service.	M77	Missing/incomplete/invalid/inappropriate place of service.	Service billed not compatible with patient location. Procedure is payable only if client lives in a rural county (not Weber, Davis, Utah, Salt Lake)	3
				Place of service must be office.	3
				Place of service limit for procedure	3
				Invalid place of service for procedure. Only covered through a FQHC.	3
6	The procedure/revenue code is inconsistent with the patient's age.			Dental Procedure is not appropriate for patients age.	3
				Invalid Recipient age for procedure code.	3
				CHEC services are for clients age 20 or under. Do not bill with mother's ID and B suffix.	3
				Either procedure code is age related or free vaccine is available through VFC program.	3
				This service is not a covered benefit for a person over 21 years of age.	3
				Procedure code is inconsistent with patients age, replaced with appropriate code.	3
6	The procedure/revenue code is inconsistent with the patient's age.	N129	Not eligible due to the patient's age.	For recipients 21 and over, this procedure must be performed in conjunction with an extraction.	3
7	The procedure/revenue code is inconsistent with the patient's gender.			Recipient gender invalid for procedure.	3
				Procedure is sex specific. Client is the wrong sex for procedure. Verify ID#.	3
				The procedure code is inconsistent with the patient's gender. Replaced with appropriate code.	3
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).			Proc cd not payable to FQHC	3
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.	Procedure code not payable to provider type. See manual sections 2, 7 and office lab services list.	3
				Invalid procedure code for provider.	3
9	The diagnosis is inconsistent with the patient's age.			Recipient age conflicts with the age limit for the diagnosis.	3
				Diagnosis on preadmission form 10A is inconsistent with patient age. Call preadmission unit.	3
10	The diagnosis is inconsistent with the patient's gender.			Diagnosis is sex specific. Recipient is opposite sex for diagnosis.	3
				Diagnosis on preadmission request - form 10A is for male/female only, call preadmission unit.	3

11	The diagnosis is inconsistent with the procedure.			468 is catch all DRG	3
				Procedure and Diagnosis combination not payable.	3
				All inpatient psychiatric care must have prior authorization and use psych procedure codes - see MIB 87-42	3
				The diagnosis is inconsistent with procedure	3
				Diagnosis does not indicate necessity for emergency anesthesia.	3
11	The diagnosis is inconsistent with the procedure.	N657	This should be billed with the appropriate code for these services.	Diagnosis Inconsistent with Procedure - ESRD	3
				Diagnosis Inconsistent with Procedure - Non-ESRD	3
				Diagnosis is inconsistent with procedure.	3
13	The date of death precedes the date of service.			Patient has expired.	2
				Patient expired while on Medicare	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M20	Missing/incomplete/invalid HCPCS.	ESRD requires CPT-4 code	2
				Revenue code must be billed with correct CPT-4 procedure code.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M22	Missing/incomplete/invalid number of miles traveled.	Invalid number of miles	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M47	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	No match found on history adjustment	2
				Invalid document number	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M50	Missing/incomplete/invalid revenue code(s).	Missing revenue code.	2
				Invalid revenue code - inpatient.	2
				Revenue code not on file.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M51	Missing/incomplete/invalid procedure code(s).	Missing procedure code - please bill with correct information.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M52	Missing/incomplete/invalid "from" date(s) of service.	First date of service greater than last date of service.	2
				Missing first date of service	2
				PA start date greater than end date	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M53	Missing/incomplete/invalid days or units of service.	Missing units of service.	2
				Invalid prior authorization units of service	2
				On size error, can't compute	2
				Units are greater than number of service days	2
				Units required for revenue code.	2
				Invalid prior authorization estimated days of stay	2
				Service exceed 100 lines for date	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M54	Missing/incomplete/invalid total charges.	Missing total claim charge. Please rebill with correct information.	2
				Sum of item(s) and total charge are not equal. Please correct and rebill.	2
				Invalid total non/covered charge	2
				Sum of items exceeds total charge.	2
				Reimbursement amount is greater than total charge.	2
				Invalid net charge amount	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M59	Missing/incomplete/invalid "to" date(s) of service.	Invalid last date of service	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M67	Missing/incomplete/invalid other procedure code(s).	Missing ICD-9 surgical code.	2
				Only Incidental services reported OCE 27	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M76	Missing/incomplete/invalid diagnosis or condition	Missing diagnosis code	2
				Missing a related diagnosis	2
				All Diagnosis Invalid	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M77	Missing/incomplete/invalid/inappropriate place of service.	Invalid place of service	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M79	Missing/incomplete/invalid charge.	No charge submitted on this line. Please rebill with correct information.	2
				Missing extra charge amount	2
				Invalid allowed charge amount	2
				Submitted charge not equal the rate times the unit(s)	2

16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M119	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC).	Phys admin drug codes require NDC	2
				PDL Drug - Non Preferred	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	Drug code must be billed in exact multiples of the package size.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	M126	Missing/incomplete/invalid individual lab codes included in the test.	Lab Panels Have Been Unbundled	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	Point of Sale crossover claim missing/invalid other payer information.	2
				Insufficient information regarding primary payer amount	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA30	Missing/incomplete/invalid type of bill.	Invalid inpatient type of bill.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	Date of service missing please rebill with correct	2
				Bill each surgery by single date of service	2
				First date of service greater than last	2
				Invalid action date incorrect dates in boxes 14 through 21.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA32	Missing/incomplete/invalid number of covered days during the billing period.	Total day less than covered days	2
				Total days billed is not equal to the dates of service span.	2
				Missing covered days.	2
				Invalid total days	2
				Covered days in field 7 does not equal covered units of room and board in field 46.	2
				Invalid total days billed	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA33	Missing/incomplete/invalid noncovered days during the billing period.	Client was in hospital for all/part of the date(s) of service on claim - indicate hospital leave days.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA36	Missing/incomplete/invalid patient name.	Recipient name missing	2
				Baby's first name invalid.	2
				Client name missing	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA39	Missing/incomplete/invalid gender.	Missing sex code	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA40	Missing/incomplete/invalid admission date.	Admit date after 1st service date	2
				Missing admission date.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA41	Missing/incomplete/invalid admission type.	Invalid type of admission	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA42	Missing/incomplete/invalid admission source.	Invalid source or type of admission	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA43	Missing/incomplete/invalid patient status.	Invalid patient status	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA58	Missing/incomplete/invalid release of information indicator.	Release of information not signed.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA63	Missing/incomplete/invalid principal diagnosis.	Missing primary diagnosis	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA81	Missing/incomplete/invalid provider/supplier signature.	No administrator signature	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA100	Missing/incomplete/invalid date of current illness or symptoms.	Invalid onset date	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	MA120	Missing/incomplete/invalid CLIA certification number.	CLIA provider performed microscopic procedure (PPMP certificate required)	2
				Missing required provider CLIA certification.	2
				Procedure requires a valid CLIA certificate number. Rebill with valid certificate number.	2
				CLIA certificate number being matched to national CLIA database. Allow 14 days for processing.	2
				CLIA certificate number does not match national CLIA database. Contact your state licensing agency.	2
				CLIA certificate invalid for procedure on date of service. Call state lab licensing agency.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N32	Claim must be submitted by the provider who rendered the service.	Only one provider type may be billed on a claim.	2

16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N34	Incorrect claim form/format for this service.	Incorrect claim form/format for this service.	2
				Provider number on claim is for outpatient services or claim was billed on HCFA - Use UB92	2
				Procedure code can not be billed on CHEC form. Use HCFA - 1500.	2
				Invalid Medicaid claim type.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N34	Incorrect claim form/format for this service.	Please bill preventative medicine on CHEC form - see MIB 91-38.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N37	Missing/incomplete/invalid tooth number/letter.	Missing tooth number. Please rebill with correct information.	2
				Dental Procedure is missing a valid tooth number.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N39	Procedure code is not compatible with tooth number/letter.	Invalid tooth number. Please rebill with correct information.	2
				Incorrect tooth number for procedure code	2
				Procedure code/tooth number conflict.	2
				Tooth number indicated not accurate for procedure billed. Procedure replaced with appropriate code.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N50	Missing/incomplete/invalid discharge information.	Discharge date must equal last date.	2
				Discharge date conflicts with destination.	2
				Invalid or missing discharge destination.	2
				Discharge before first service date	2
				Recipient has been discharged.	2
				Recipient discharged while on Medicare.	2
				Recipient transferred to a hospital.	2
				Recipient transferred elsewhere.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N56	Procedure code billed is not correct/valid for the service billed or the date of service billed.	Procedure code not covered on date of service.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N58	Missing/incomplete/invalid patient liability amount.	Aid in assist amount less than recipient amounts.	2
				Other income amount less than recipient amounts.	2
				Invalid other income amount	2
				Suspended crossover	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N63	Rebill services on separate claim lines.	Residential services or one per day services have been billed with overlapping dates.	2
				Bill each surgery by single date of service	2
				Dates of service overlap calendar months - rebill with each month on separate line.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N75	Missing/incomplete/invalid tooth surface information.	Missing tooth surface. Please rebill with correct information.	2
				Invalid tooth surface. Please rebill with correct information.	2
				Dental Procedure is missiing a valid tooth surface code.	2
				Reserved for CCE - Validation replacement	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N152	Missing/incomplete/invalid replacement claim information.	Missing credit TCN	2
				Credit/Debit suspended for validity	2
				Replacement claim (orig claim not found)	2
				Replacement / void received for claim	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N208	Missing/incomplete/invalid DRG code.	Missing assigned DRG	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N253	Missing/incomplete/invalid attending provider primary identifier.	Missing the attending physician license number.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	Missing provider number.	2
				Invalid provider number	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N261	Missing/incomplete/invalid operating provider name.	Missing surgeon name or license number	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N277	Missing/incomplete/invalid other payer rendering provider identifier.	Invalid servicing license number	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N286	Missing/incomplete/invalid referring provider primary identifier.	Missing or invalid PCP name and UPIN. Rebill claim with correct PCP name and UPIN.	2
				No valid referral for service date. Please send referral and copy of this page.	2
				Missing referring provider name or license number. Please rebill with correct information.	2

16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N286	Missing/incomplete/invalid referring provider primary identifier.	Invalid referring license number	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N291	Missing/incomplete/invalid rendering provider secondary identifier.	Missing servicing provider's license number.	2
				Invalid Pay-To Provider Number	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N293	Missing/incomplete/invalid service facility primary identifier.	Valid hospital provider needed	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N297	Missing/incomplete/invalid supervising provider primary identifier.	Invalid supervisor provider - check digit.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N305	Missing/incomplete/invalid injury/accident date.	Accident date after last date of service.	2
				Invalid accident related indicator	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N317	Missing/incomplete/invalid discharge hour.	Invalid discharge hour.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N318	Missing/incomplete/invalid discharge or end of care date.	Invalid discharge date	2
				Last date of service prior to end of month and TAD does not have a discharge date.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N329	Missing/incomplete/invalid patient birth date.	Invalid date of birth	2
				Birth Dates Not The Same	2
				Missing newborn date of birth	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N330	Missing/incomplete/invalid patient death date.	Invalid date of death	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N341	Missing/incomplete/invalid surgery date.	Missing date of surgery	2
				Surgery date not within dates of service	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N346	Missing/incomplete/invalid oral cavity designation code.	Dental Procedure is missing valid quadrant or arch indicator.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N382	Missing/incomplete/invalid patient identifier.	Missing recipient ID number. Rebill claim with correct information.	2
				Recipient ID number is invalid. Rebill claim with correct information.	2
				Invalid recipient ID number.	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	Crossover claim line TPL is negative and should not have a negative amount.	2
				Invalid third party pay amount	2
16	Claim/service lacks information or has submission/billing error(s). Do not use this code for claims attachment(s)/other documentation.	N755	Missing/incomplete/invalid ICD indicator.	Missing diagnosis indicator	2
18	Exact duplicate claim/service.			Medicaid has record of a previous payment for this service.	2
				Too many claims UB-25/Others-45	2
				ICF Exact Duplicate	2
				Service has already been billed and is being considered for payment or has been paid.	2
				Surgical session - two claims.	2
				Duplicate Dental Services	2
				Duplicate Dental Services, same Provider.	2
				LTC exact duplicate claim this cycle	2
				These services have been paid for by Medicare.	2
				Exact duplicate of a paid claim	2
				Drug/Chemical duplication not allowed.	2
				Dates of service are same or overlap an already paid claim.	2
				Home and community based services paid claim conflict.	2
				Exact duplicate of another claim - previous claim is suspended or has already been paid.	2
				Duplicate payment - case management fee	2
				Manual review of dental claim processed by CCE.	2
				Duplicate/conflicting surface	2
22	This care may be covered by another payer per coordination of benefits.			These services have been paid for by Medicare.	3
				Over 65 potential Medicare coverage	3
				Recipient has medical insurance.	3
				Other insurance amount missing.	3

22	This care may be covered by another payer per coordination of benefits.			Claim has third party payment.	3
				Absentee parent responsible.	3
				Claim indicates accident.	3
				Invalid insurance company code	3
				Drug TPL coverage.	3
				Medicare within date(s) of service. No attachment - please bill Medicare for these services.	3
				Recipient eligible for Medicare. Please bill Medicare for this service.	3
				Recipient eligible for Railroad Medicare. Please bill Travelers Railroad Medicare.	3
				Recipient eligible for Medicare. Date(s) of service overlap coverage. Please bill Medicare.	3
				Recipient eligible for Railroad Medicare. DOS overlap coverage. Bill Travelers Railroad Medicare.	3
				Potential Medicare eligible recipient.	3
				Potential Railroad Travelers Medicare.	3
				SSA potential	3
				SSA 65/over final DOS no attempt accrete	3
				RR 65/over final DOS no attempt accrete	3
				Medicare/third party liability coverage overlaps.	3
				RR Medicare and third party liability coverage overlaps.	3
				Bill Medicaid for coinsurance/deductible payment for mental health services to non-QMB clients.	3
				Crossover Service Only - Bill Medicare.	3
				Patient transferred to Medicare.	3
				Amount Billed less than minimum - Recipient has insurance	3
				Dental bill amount less than minimum - Recipient has insurance.	3
				Client has third party liability.	3
22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	Recipient has TPL - claim with attachment.	3
				Dental - Claim has attachment - Recipient has medical insurance	3
				Claim has attachment - Recipient has medical insurance	3
				TPL billed less than minimum - Recipient has insurance.	3
				TPL not reported on crossover claim	3
22	This care may be covered by another payer per coordination of benefits.	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	Claim not covered by this payer. Submit claim to crossover.	3
				RR Medicare within date of service with third party liability.	3
24	Charges are covered under a capitation agreement/managed care plan.			Client is enrolled in Delta Care.	4
				Client is enrolled in Premier Access	4
				Client is enrolled in MCNA Dental	4
				Service covered under mental health contract.	4
				Claim is for SUD services and provider is not the Substance Use Disorder provider on record.	4
				Service covered by CHP, 4213 S. Holladay Blvd. #202, SLC, UT 84124	4
				Recipient enrolled in UNI home	4
				Molina client received fee for service.	4
				Rendering provider is not eligible to perform the services billed. IHC client.	4
				Recipient enrolled in Healthy U.	4
				Client enrolled in a HMO for date of service. Bill client's HMO	4
				Recipient enrolled in IHC Access	4
				Client enrolled in Health Choice Utah. Bill Health Choice Utah.	4

24	Charges are covered under a capitation agreement/managed care plan.			Health Choice Utah client received fee for service. Bill Health Choice Utah.	4
				Client enrolled in Molina	4
				Recipient enrolled in AFC Plus	4
27	Expenses incurred after coverage terminated.			Recipient not eligible - has clean MI-706.	3
29	The time limit for filing has expired.			Billing deadline exceeded - submit payment adjustment request and document reason for delay.	3
				Exceeded 90 day billing deadline for aging waiver services.	3
				Date(s) of service exceeds 3 years	3
31	Patient cannot be identified as our insured.			Claim denied pending correct ID#. Please rebill with correct information.	3
				Recipient ID not on our Medicaid file.	3
				Client ID with “B” suffix indicates newborn services. Birthdate is not for a newborn.	3
				Baby is ineligible for Utah Medical Assistance Program or presumptive eligibility.	3
				No record of client on baby your baby program.	3
				UMAP client identification number is not on the Medicaid eligibility file - see form MI-706	3
35	Lifetime benefit maximum has been reached.			Exceeds 1 initial assessment for TCM - Benefit maximum has been reached	3
				Exceeds 1 face to face follow-up - Smoking Cessation - Benefit maximum for this time period has been reached.	3
39	Services denied at the time authorization/pre-certification was requested.			Recipient remains private pay.	3
				Recipient transferred to a Home and Community based setting.	3
				Recipient status goes to private pay.	3
				Facility did not meet patient’s needs.	3
40	Charges do not meet qualifications for emergent/urgent care.			Emergency exam not payable because Medicaid has paid for other dental procedures on this DOS.	3
				Non-covered emergency room visit per diagnosis submitted.	3
				Emergency room charges are payable for admission types 1 or 2 only.	3
				Svcs don't qualify for emergency care	3
50	These are non-covered services because this it not deemed a 'medical necessity' by the payer.			Recipient denied. No medical need.	3
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	Emergency Only Client	3
54	Multiple physicians/assistants are not covered in this case.			Multiple Surgeons Assistant not allowed	3
				Assistant surgeon not covered. See assistant surgeon list.	3
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.			Provider has billed for Inpatient Services on an Outpatient Claim (OCE 45 and 49).	3
				Recipient denied. Inappropriate placement.	3
				Recipient did not enter nursing home facility.	3
				Inpatient only service billed on professional claim.	3
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia).			More than one anesthesia service on same date/ not OB exception - See Medicaid bulletin 90-08	3
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.			Services 3 days prior to admit are part of DRG payment - see MIB 91-49	3
				Emergency room not payable.	3
				Emergency room/other services not payable.	3
				Outpatient services on this claim should be included on the inpatient claim for recipient.	3
				Conflict outpatient claim - credit outpatient claim and submit inpatient claim with outpatient charges included or adjust and document two services.	3
96	Non-covered charge(s).	M2	Not paid separately when the patient is an inpatient.	Inpatient occupational therapy services is not a covered benefit.	3
				Dates of service overlap a nursing home/hospital stay. Please split bill.	3

96	Non-covered charge(s).	M2	Not paid separately when the patient is an inpatient.	Dates of service conflict with a nursing home/inpatient hospital claim.	3
				Targeted case management for homeless (Y3110) has been billed on dates that overlap hospital/nursing home stay.	3
				Inpatient services have been paid for one or more dates of service. Please split bill.	3
				Inpatient/nursing home services have been paid for one or more date(s) of service. Split bill.	3
96	Non-covered charge(s).	M2	Not paid separately when the patient is an inpatient.	Dates of service overlap a hospital stay. Please split bill.	3
				Dates of service on this claim overlap dates of service on a paid inpatient claim.	3
				Service not covered while the client is in the hospital.	3
				Hospital coverage exceeds Medicaid limits.	3
				Hospital days exceeded Medicaid limits	3
96	Non-covered charge(s).	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Personal care/home health conflict	3
				Medically unlikely edits	3
				Service overlap for home and community based service, targeted case management or ICF/MR day treatment.	3
96	Non-covered charge(s).	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	Client Resides in State Hospital Pharmacy claims not covered.	3
96	Non-covered charge(s).	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	Contracted codes not payable to provider.	3
96	Non-covered charge(s).	N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.	Service denied by Medicare, non-covered through crossovers.	3
96	Non-covered charge(s).	N10	Adjustment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	Review All Claims For Recipient.	3
				Claim denied after professional review - see provider manual for appeal rights.	3
				Service denied after professional review.	3
				Claim denied after professional review.	3
96	Non-covered charge(s).	N30	Patient ineligible for this service.	Custody medical care claims.	3
				Client eligible for Medicaid, but not for this specialized program service.	3
				Emergency only client non covered svc	3
				Nursing home claim PCN eligible	3
96	Non-covered charge(s).	N43	Bed hold or leave days exceeded	Excess Leave of Absence Days Exceeds 25 per Calendar Quarter and no Prior Auth.	3
				Invalid hospital leave days	3
96	Non-covered charge(s).	N54	Claim information is inconsistent with pre-certified/authorized services.	LTAC Srvs for this client, date range, rate, or provider are not on the current table.	3
96	Non-covered charge(s).	N61	Rebill services on separate claims.	Two categories of service on same claim or provider not authorized to perform service.	3
96	Non-covered charge(s).	N95	This provider type/provider specialty may not bill this service.	Invalid revenue code for ESRD	3
				Invalid revenue code for outpatient claims.	3
96	Non-covered charge(s).	N129	Not eligible due to the patient's age.	Proc not payable for age or prov type.	3
				Root canals not covered for this tooth.	3
96	Non-covered charge(s).	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	Personal care/home health conflict	3
				Compound not covered for program type	3
96	Non-covered charge(s).	N157	Transportation to/from this destination is not covered.	HMO ambulance claims paid by Medicaid - Non covered service	3
96	Non-covered charge(s).	N161	This drug/service/supply is covered only when the associated service is covered.	Claims service lacks information needed for adjudication (Non-emergent Transportation for IHS).	3
				Non-covered vaccine administration when vaccine is also non-covered.	3
96	Non-covered charge(s).	N188	The approved level of care does not match the procedure code submitted.	TAD has date(s) in boxes 14 through 21 and action/reason code missing or invalid.	3
96	Non-covered charge(s).	N198	Rendering provider must be affiliated with the pay-to provider.	Servicing provider unaffiliated with group practice. Contact Medicaid.	3
96	Non-covered charge(s).	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	Noncovered Medicaid benefit.	3
				Cross-over claim is not a covered benefit for UMAP clients.	3

96	Non-covered charge(s).	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	Chiropractic services not covered by Medicaid for dates of service 7/1/88 to 1/1/89.	3
				Service denied by Medicare, non-covered through crossovers.	3
96	Non-covered charge(s).	N362	The number of Days or Units of Service exceeds our acceptable maximum.	Number of miles exceeds 30	3
				Excessive number of units submitted.	3
96	Non-covered charge(s).	N431	Not covered with this procedure.	Procedure code is not a covered Medicaid benefit for the date of service.	3
				Dental Procedure Code not covered.	3
				Surgery provided is not a covered benefit or requires a separate PA. See surgical PA list.	3
				Dental Procedure code not covered on date of service.	3
				All surgical procedures on this claim are invalid	3
				Principal surgical procedure not covered by Medicaid.	3
				Other surgical procedure code listed in form locator 81 is not a covered benefit.	3
96	Non-covered charge(s).	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	Non-covered Medicaid revenue code.	3
				Inpatient and outpatient observation not covered.	3
				Code adjusted to an alternate procedure	3
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.			A bundled service for residential treatment has been paid.	4
				A claim has been paid for a bundled code with overlapping dates.	4
				Bundled procedure/history or paid claim	4
				Date(s) of service on this claim overlap a paid outpatient claim.	4
				COG service included in package procedure	4
				Medicaid paid a package procedure which included this cognitive service	4
				Package procedure has history of claim cognitive service.	4
				Payment included with dental package procedure.	4
				Payment included in package procedure	4
				Dental exam included with payment of another code.	4
				Dental exam included with payment of paid claim - history	4
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	A bundled service for residential treatment has been paid.	4
				Payment included in another service. Re-bundled services not paid separately.	4
				Rebundled - 2 or more procedures billed when a single more comprehensive code exists	4
				Rebundled procedure due to history claim	4
				Rebundled dental service not paid separately	4
				Rebundled dental service not paid separately - history claim	4
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Dental Procedure is not eligible in combination of previously paid procedure code.	4
				Dental Procedure is unbundled to a previously paid procedure.	4
				Dental Procedure is unbundled to another procedure on same claim.	4
				Readmit within same date of service - combine bills.	4
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86	Service denied because payment already made for same/similar procedure within set time frame.	Medicaid has made payment for all or part of this service.	4
				This service is included in Medicaid's global payment for delivery.	4
				Two global - Medicaid has paid for this service.	4
				Medicaid has paid a global payment for this delivery.	4
				Conflict - Antepartum - Medicaid has already paid for this service.	4
				2 postpartum claims - Medicaid has already paid for this service.	4
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	Covered by DRG payment to hospital	4

97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N19	Procedure code incidental to primary procedure.	Payment is included in the allowance for another service or primary procedure	4
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.	Injection part of aspiration	4
				Aspiration/injection conflict	4
				A bundled service for residential treatment has been paid.	4
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.	Skilled nursing/supportive maintenance/home health aid visit same day.	4
				Extended supportive maintenance nurse visit conflict.	4
				Skilled nursing/supportive maintenance/home health aide conflict	4
				Attendance at delivery and newborn resuscitation billed on same day.	4
				This E/M service not paid separately with therapeutic or diagnostic procedure billed.	4
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N525	These services are not covered when performed within the global period of another service.	OB multiple units same claim.	4
				Dental Procedure is included within a Global Period of another procedure.	4
107	The related or qualifying claim/service was not identified on this claim.			Prolonged Services	2
				Office call is invalid for CHEC services. Use box 44 for screening charges.	2
				Must have completed a high risk assessment to receive payment for a high risk delivery.	2
				VFC immunization procedure code must be billed with administration code.	2
				Please bill with D9220. Cannot be billed separately. See dental provider manual.	2
107	The related or qualifying claim/service was not identified on this claim.	MA66	Missing/incomplete/invalid principal procedure code.	Qualifying circumstances must be billed in conjunction with an anesthesia service	2
107	The related or qualifying claim/service was not identified on this claim.	N122	Add-on code cannot be billed by itself.	Some CPT Codes may not be billed on their own, they have to be billed with the parent code.	2
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.			Member enrolled in Select Health IMED Physical Health	3
				Member enrolled in Health Choice IMED Physical Health	3
				Member enrolled in Healthy U IMED Physical Health	3
				Member enrolled in Molina IMED Physical Health	3
				Home and community based services must be submitted through social services.	3
				Nonexempted subsidized adoption, bill PMHP or DHS.	3
				Medicaid coverage denied prior to 7/1/87. Bill OSCA, 150 W. North Temple, SLC, UT 84103	3
				Services are covered in the ICF/MR per diem. Bill ICF/MR.	3
				Practitioner should be paid by nursing home for dates of service that are in conflict. Contact nursing home.	3
				Member enrolled in Select Health IMED Behavioral	3
				Member enrolled in Health Choice IMED Behavioral	3
				Member enrolled in Healthy U IMED Behavioral	3
				Member enrolled in Molina IMED Behavioral	3
				Client enrolled with Weber Macs	3
				Recipient enrolled in United Flexcare	3
				Recipient enrolled in IHC Access	3
				Client is enrolled in Molina Independence care long term care HMO. Bill Molina for services.	3
				Molina plus client received fee for service.	3
				Client enrolled in HMO	3
110	Billing date predates service date.			Date of service is after the date the claim was received.	2
				Billing date before services given	2
				Invalid billing date	2
				Service date after claim received	2
				Billing date in error	2

119	Benefit maximum for this time period or occurrence has been reached.			Prescription Limit Exceeded for Month.	3
				Dual Medicare eligiblility not established.	3
119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	Drug testing exceeds 60 combined tests allowed per year.	3
				Drug testing exceeds 16 combined tests allowed per year.	3
				PCN Preventive Health Exam - one per year	3
119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	Exceeds 1 unit of RN maintenance care every 60 days	3
				Lithotripsy by physicians is limited to 2 per 90 days	3
				Provider has billed over 3 per 3 month limit for hearing aid loaner rental.	3
				Respite care services 31 per 1 month limit is exceeded.	3
				Medicaid has paid 1 day treatment habilitation service for this date of service or units exceed 1.	3
				Exceeds dental prophylaxis limit	3
				Exceed sealant limit per tooth	3
				Crown preparation limit per tooth	3
				Exceeds dental crown limit	3
				Exceeds X-ray limits	3
				Exceeds 1 per day limit for tooth	3
				Exceeds 2 follow-up phone contacts - Smoking Cessation - Benefit maximum for this time period has been reached	3
				Exceeds Dental Limits.	3
				Duplicate procedure exceeds unit limit.	3
119	Benefit maximum for this time period or occurrence has been reached.	M90	Not covered more than once in a 12 month period.	PCN Preventive Health Exam - one per year	3
				Exceeds 1 evaluation per year. Requires prior authorization	3
				Exceeds 1 consultation per year without a prior authorization	3
				Vision limit exceeded	3
119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	Home health initial visit exceeds one per admission	3
				Drug testing exceeds 60 combined tests allowed per year.	3
				Home health supplies exceeds allowable	3
				Drug testing exceeds 16 combined tests allowed per year.	3
				Service Exceeds 6 per 12 Month Limit	3
				One per month benefit maximum reached.	3
				Exceeds 1 unit of RN maintenance care every 60 days	3
				Lithotripsy by physicians is limited to 2 per 90 days	3
				Lithotripsy for outpatient is limited to 2 per 90 days	3
				Exceeds routine home care 1 per day limit	3
				Exceeds hospice services 1 per day limit	3
				Provider has billed over 3 per 3 month limit for hearing aid loaner rental.	3
				Personal care assessment is limited to 1 every 6 months	3
				Exceeds 640 units per month	3
				Respite care services 31 per 1 month limit is exceeded.	3
				School district services only allowed 1 per day.	3
				Medicaid has paid 1 day treatment habilitation service for this date of service or units exceed 1.	3
				Exceeds occlusal adjustments limit. See MIB 91-63.	3
				Exceeds two per year.	3
				Exceeds dental examination limit of two per year for this client.	3
				Exceeds dental prophylaxis limit	3
				Exceed sealant limit per tooth	3
				Crown preparation limit per tooth	3
				Exceeds dental crown limit	3
				Only one allowed per month (Perinatal care coordination exceeds 1 per 30 day limit).	3
				Risk assessment services are limited to 2 per 10 months.	3

119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	Group pre/postnatal education exceeds 8 per 12 months limit.	3
				Nutritional assessment/counseling exceeds 14 per 12 months limit	3
				Psychosocial counseling exceeds 10 per 12 months limit	3
119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	Pre/postnatal home visits exceeds 6 per 12 months limit.	3
				Prenatal assessment visits exceeds 1 per 10 months limit.	3
				Single prenatal visits exceeds 3 per 10 months limit.	3
				Exceeds 1 per pregnancy limit for global, high risk maternity care, vaginal delivery code.	3
				High risk global maternity care, cesarean section service is limited to 1 per pregnancy.	3
				Comprehensive high risk pregnancy consult by multispecialty team exceeds 1 per 10 month limit.	3
				Exceeds 1 case management service per day limit.	3
				Exceeds X-ray limits	3
				Exceeds 1 per day limit for tooth	3
				D7110 one per day limit exceeded.	3
				Exceeds Dental Limits.	3
				Duplicate procedure exceeds unit limit.	3
				Exceeds units of service limits.	3
				I.H.S. services are limited to one air per day. Additional claims will pay zero	3
119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	Exceeds routine home care 1 per day limit	3
				Exceeds hospice services 1 per day limit	3
119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	Prior approval required after 156 per month maximum is exceeded	3
				Benefit maximum for this time period or occurrence has been reached.	3
				Exceeds hospice services 1 per day limit	3
				Procedure code limited to 12 units per calendar year	3
				Excessive number of units submitted.	3
				Exceeds a limit per calendar year for this procedure - see section 7 of your provider manual.	3
				Exceeds respite care limit of 5 consecutive days	3
				Original line denied, exceeds unit limit	3
119	Benefit maximum for this time period or occurrence has been reached.	N411	This service is allowed one time in a 6-month period.	Personal care assessment is limited to 1 every 6 month	3
119	Benefit maximum for this time period or occurrence has been reached.	N412	This service is allowed 2 times in a 12-month period.	Exceeds two per year.	3
				Exceeds dental examination limit of two per year for this client.	3
				High risk pregnancy team follow-up exceeds 2 per 12 months limit.	3
119	Benefit maximum for this time period or occurrence has been reached.	N435	Exceeds number/frequency approved/allowed within time period without support documentation.	Prior approval required after 156 per month maximum is exceeded	3
				Exceeds 1 evaluation per year. Requires prior authorization	3
				Exceeds 1 consultation per year without a prior authorization	3
				Procedure code limited to 10 units per 12 months	3
119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	Home health initial visit exceeds one per admission	3
				Home health supplies exceeds allowable	3
				Service Exceeds 6 per 12 Month Limit	3
				One per month benefit maximum reached.	3
				Lithotripsy for outpatient is limited to 2 per 90 days	3
				Exceeds 640 units per month	3
				School district services only allowed 1 per day.	3
				Exceeds occlusal adjustments limit. See MIB 91-63.	3
				Only one allowed per month (Perinatal care coordination exceeds 1 per 30 day limit).	3

119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	Risk assessment services are limited to 2 per 10 months.	3
				Group pre/postnatal education exceeds 8 per 12 months limit.	3
				Nutritional assessment/counseling exceeds 14 per 12 months limit	3
				Psychosocial counseling exceeds 10 per 12 months limit	3
				Pre/postnatal home visits exceeds 6 per 12 months limit.	3
				Prenatal assessment visits exceeds 1 per 10 months limit.	3
				Single prenatal visits exceeds 3 per 10 months limit.	3
				Exceeds 1 per pregnancy limit for global, high risk maternity care, vaginal delivery code.	3
				High risk global maternity care, cesarean section service is limited to 1 per pregnancy.	3
				Comprehensive high risk pregnancy consult by multispecialty team exceeds 1 per 10 month limit.	3
				Exceeds 1 case management service per day limit.	3
				D7110 one per day limit exceeded.	3
				Exceeds units of service limits.	3
				I.H.S. services are limited to one air per day. Additional claims will pay zero	3
140	Patient/Insured health identification number and name do not match.			Service date greater than 30 days from date of birth	2
				Invalid newborn sex code	2
				Bill service under baby's own identification number.	2
				Bill service under mother's identification number.	2
				Can't match name on submitted claim to name on recipient file, name mismatch.	2
146	Diagnosis was invalid for the date(s) of service reported.			DOS before diagnosis is effective.	2
				All diagnosis(es) on this claim are not covered by Medicaid	2
149	Lifetime benefit maximum has been reached for this service/benefit category.	N117	This service is paid only once in a patient's lifetime.	Duplicate lifetime same or different claim	3
150	Payer deems the information submitted does not support this level of service.			Medical needs supersedes nursing home.	3
				Per diem/level of care conflict	3
				E/M higher intensity than expected per diagnosis	3
				Claim/service adjusted because information submitted does not support this level of service.	3
				Reserved for CCE - surface validation upcoding	3
155	Patient refused the service/procedure.			Recipient denied. Patient left against medical advice	3
167	This (these) diagnosis(es) is (are) not covered.			Primary diagnosis is not covered by Medicaid.	3
				Secondary diagnosis not covered by Medicaid.	3
				Third diagnosis not covered by Medicaid	3
				Fourth diagnosis not covered by Medicaid	3
				Fifth diagnosis not covered by Medicaid	3
				Invalid long term care diagnosis code	3
170	Payment is denied when performed/billed by this type of provider.			Physician is not a radiologist. Procedure limited to radiology specialty.	3
170	Payment is denied when performed/billed by this type of provider.	N95	This provider type/provider specialty may not bill this service.	Procedure Code not payable to provider type.	3
				Ambulatory Surgical Center has billed a code that needs reviewed for price amount.	3
				Case management fee - inventory cost	3
				Provider specialty, surgical service, or procedure is not covered in client's plan.	3
171	Payment is denied when performed/billed by this type of provider in this type of facility.	N428	Not covered when performed in this place of service.	Physician not pathologist or not performing procedure in lab or hospital - call provider enrollment.	3
177	Patient has not met the required eligibility requirements.			Client is not eligible on the date of service.	3
				Client is eligible for Medicare but not eligible for Medicaid.	3
				Recipient ineligible on dates of service. Resubmit claim with EOMB attached.	3
				Recipient ineligible for Medicaid.	3

177	Patient has not met the required eligibility requirements.			Patient on leave of absence or extended leave.	3
				Not eligible for Medicaid payment.	3
				Recipient is not eligible on service date - if you have copy of card, submit with adjustment.	3
178	Patient has not met the required spend down requirements.			Recipient is not eligible on service date. If you have copy of MEEU, submit with this page.	3
				Recipient not eligible all service dates	3
				Recipient is not eligible on service date	3
181	Procedure code was invalid on the date of service.			Dental code is no longer a valid CDT Code.	2
				Procedure code unknown by Medicaid. Please rebill with correct information.	2
				CPT Code on Dental Claim	2
				DOS before surgery is effective.	2
				Invalid procedure code	2
				DOS before Rev code effective	2
182	Procedure modifier was invalid on the date of service.			Modifier not covered on date of service.	2
				Modifier unknown by Medicaid.	2
				Modifier non-covered by Medicaid.	2
183	The referring provider is not eligible to refer the service billed.			Provider is not authorized to refer	3
185	The rendering provider is not eligible to perform the service billed.			Can't calculate payment - bad data.	3
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay..	N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	Service is included in flat rate payment to the nursing home where recipient resides.	4
				Medicare coverage for medical supplies to recipient in nursing home.	4
197	Precertification/authorization/notification/pre-treatment absent.			Missing prior authorization number.	3
				Prior authorization number for inpatient psychiatric services is missing or invalid.	3
				Diagnosis requires prior authorization.	3
				Invalid PA hospital length of stay.	3
				Invalid PA hospital approval code.	3
				Invalid PA requested units.	3
				Surgical procedure requires prior authorization.	3
				No prior authorization for procedure code that has prior authorization required for dollar limit.	3
				Out of state provider.	3
				Missing pre-admission document number.	3
				Non-emergency transportation services must have a prior authorization.	3
				No Medicaid prior authorization in the system. Call Medicaid for prior authorization.	3
				These services require a Medicaid prior authorization.	3
				Disability payment must have MI-706 authorization.	3
				Procedure requires prior authorization or has a unit limit which has been exceeded	3
				Procedure requires prior authorization when done inpatient. If PA on claim, it does not cover service or PA has not cleared Medicaid.	3
				Missing MI-706 number on claim for UMAP client. Resubmit claim with valid MI-706 number.	3
				Diagnosis billed on claim is abortion related. All related services require prior authorization.	3
				Claim needs prior authorization number	3
				Invalid prior authorization procedure - in office code	3
				Prior authorization document number equal to zero	3
				Missing MI-706 number for UMAP client. Lab service billed with CLIA certificate number. Resubmit correct MI-706	3
				Line added, requires prior authorization, different code than prior authorization.	3

197	Precertification/authorization/notification/pre-treatment absent.			Line added require a prior authorization, original code did not require prior authorization.	3
198	Precertification/notification/authorization/pre-treatment exceeded.			All prior authorized units/amounts have been used on previously paid claim.	3
198	Precertification/notification/authorization/pre-treatment exceeded.			Approved hospital inpatient or outpatient units have been used on a previous claim.	3
				All approved units for an inpatient psychiatric stay have been used on this or another claim.	3
				All prior approved units for this service have been used on previously paid claims.	3
				Hospital leave days exceed 3. Please submit new pre-admission (form 10A)	3
				Approved units on prior authorization(s) will be exceeded with the units on this claim.	3
199	Revenue code and Procedure code do not match.			Incorrect billing of Rev Code with HCPCS OCE 44 and/or 79	2
200	Expenses incurred during lapse in coverage.			Client is not eligible on the date of service. Patient is not covered.	3
204	This service/equipment/drug is not covered under the patient's current benefit plan.			Presumptive eligibility program does not cover inpatient hospital or nursing home benefits.	3
206	National Provider Identifier - Missing			Claim submitted without NPI and provider is a covered entity.	2
207	National Provider Identifier - Invalid format.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	National Provider Identifier on claim is not valid or other than 10 digits.	2
207	National Provider identifier - Invalid format	N262	Missing/incomplete/invalid operating provider primary identifier.	Invalid surgeon's license number.	2
207	National Provider identifier - Invalid format	N286	Missing/incomplete/invalid referring provider primary identifier.	Referring provider not found.	2
				Missing or invalid PCP name and UPIN. Rebill claim with correct PCP name and UPIN.	2
208	National Provider Identifier - Not matched.			National provider Identifier not matched. Servicing provider NPI matched.	2
231	Mutually exclusive procedures cannot be done in the same day/setting.			Dental procedure combination not expected. Payment included in the allowance for another service.	3
				Dental code is mutually exclusive of another code.	3
				Dental Procedure not eligible due to a previous paid procedure.	3
				Dental Procedure is mutually exclusive to a previous paid procedure code.	3
				Mutually Exclusive Current Claim	3
				Mutually Exclusive History Claim	3
				Procedure combo billed are not expected to be performed during the same encounter	3
				Procedure combo not expected same day, paid claim in history	3
				Dental procedure combo not expected same day	3
				Dental procedure combo not expected same day - paid claim history	3
				Current procedure mutually exclusive to history procedure.	3
				History procedure mutual exclusive to current procedure.	3
233	Services/changes related to the treatment of a hospital-acquired condition or preventable medical error.			Claim has POA indicating DX was not present on admit & is a never pay event.	3
234	This procedure is not paid separately.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	Provider billed individual lab codes when a Lab Panel is more appropriate.	4
				Dental Procedure is to be rebundled with other procedures on claim. Rebill with bundled procedure code.	4
				Dental Procedure code has been rebundled to bundled	4
234	This procedure is not paid separately.	N20	Service not payable with other service rendered on the same date.	History Lab Panels Have Been Unbundled	4
				DOS conflict aging waiver	4
				DOS conflict with substance abuse service.	4
				Nursing home/hospital claim overlapping targeted case management claim dates of service.	4
				Home and community based services paid claim conflict	4

234	This procedure is not paid separately.	N20	Service not payable with other service rendered on the same date.	Nursing home or inpatient conflict with personal care or targeted case management.	4
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/fee schedule requirements.			Procedure is incidental to another procedure.	2
				Current procedure incidental to other current procedure.	2
				Emergency exam can not be paid when other services are billed on same date of service.	2
				OB Global unbundled current to current.	2
				OB Global unbundled to history.	2
				Unbundled Procedure Current Claim	2
				Unbundled Procedure History Claim	2
				History procedure incidental to other current procedure.	2
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.			Recipient is not eligible for all dates of service. See medical card. Form 695 or MI-706	3
				Claim has multiple dates of service and client isn't eligible for some of the dates.	3
				Client not eligible on all dates of service	3
242	Services not provided by network/primary care providers.	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	No provider master record.	3
243	Services not authorized by network/primary care providers.			Client has interim eligibility for service date. Please mail a copy of form 695.	3
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.	M135	Missing/incomplete/invalid plan of treatment.	Nursing home did not follow pre-admission requirements.	1
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.	N228	Incomplete/invalid consent form.	Invalid sterile interpretation date	1
				Invalid sterile consent date	1
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.	N705	Incomplete/invalid documentation.	Insufficient data to make a determination.	1
252	An attachment/other documentation is required to adjudicate this claim/service.	M23	Missing invoice.	Procedure requires manual pricing. Mail documentation with remittance advice.	1
252	An attachment/other documentation is required to adjudicate this claim/service.	M29	Missing Operative note/report.	Multiple Surgeon manual review	1
252	An attachment/other documentation is required to adjudicate this claim/service.	N28	Consent form requirements not fulfilled.	Prior authorization and/or sterilization consent form not at Medicaid.	1
				Prior authorization and/or consent to abortion not at Medicaid.	1
				Prior authorization and/or hospital surgical consent form not at Medicaid.	1
252	An attachment/other documentation is required to adjudicate this claim/service.	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	Dental code is an unlisted procedure code, submit documentation with description of service.	1
				Unlisted Procedure	1
252	An attachment/other documentation is required to adjudicate this claim/service.	N706	Missing documentation.	Procedure requires manual review. Send documentation with copy of remittance advice.	1
				Modifier requires manual review.	1
				Emergency only program - do not rebill claim. Mail records with copy of remittance advice.	1
				PPC DX for a DRG Claim but requires medical review to exclude HCAC associated charges.	1
252	An attachment/other documentation is required to adjudicate this claim/service.	N729	Missing patient medical/dental record for this service.	Bilaterally missing teeth	1
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.			DJJS Medical Claims	3
				Services not covered while Institutionalized. Inpatient services only.	3
				Adult criminal court jurisdiction.	3
				Juvenile criminal court jurisdiction.	3
268	The claim spans two calendar years. Please resubmit one claim per calendar year.			Dates of service overlap calendar year	2
272	Coverage/program guidelines were not met.			Nursing home does not have an available bed.	3
				Families First Coronavirus Response Act	3
				Same day service, bill claim as outpatient	3

272	Coverage/program guidelines were not met.			Bill as outpatient	3
273	Coverage/program guidelines were exceeded.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	Benefit maximum for this time period or occurrence has been reached.	3
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.			Primary diagnosis not covered 10A	2
				Secondary diagnosis not covered 10A	2
				Recipient on TAD does not match recipient on preadmission request form 10A	2
				DRG on claim not DRG on PA - This prior authorization is not for this service.	2
				Exceeds approved services on MI-706	2
				This procedure was not authorized on the original MI-706.	2
				No clean form 10A at Medicaid. Medicaid will reprocess claim when form 10A is corrected.	2
				Claim submitted does not match prior authorization.	2
				Procedure code on claim is not the procedure code approved on prior authorization.	2
				Procedure code and/or date on claim does not match any prior authorization in system.	2
				Claim type can not have a prior authorization.	2
				Invalid preadmission match - invalid claim type for service.	2
				TAD dates not equal to dates on 10A	2
				Level of care not authorized	2
				PA number on claim does not match any PA in Medicaid file - PA number may not exist or has errors.	2
				Cannot use Medicaid prior authorization for UMAP client. You must have MI-706 for claim.	2
				Tooth number not authorized.	2
				PA dates invalid.	2
				MI-706 number on this claim does not match any MI-706 processed by Medicaid.	2
				The procedure on the claim was not authorized on the MI-706	2
				Hospital inpatient or outpatient services not approved on prior authorization.	2
				Surgical code billed on claim does not match surgical code on prior authorization.	2
				An inpatient psychiatric stay must be prior approved.	2
				Prior authorization was not approved for inpatient psychiatric services.	2
				Services related to abortion must have a prior approval.	2
				No clean PC-701 in system	2
				Preadmission form 10A has invalid diagnosis	2
				UMAP client - no MI706	2
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.			Provider on claim not provider on prior authorization or preadmission request (form 10A)	2
A6	Prior hospitalization or 30 day transfer requirement not met.			Urban hospital readmit within 30 days.	3
				Rural hospital readmit within 30 days.	3
				Readmit within 30 days - different hospitals.	3
A8	Ungroupable DRG			Invalid principal diagnosis code/DRG	2
				Unable to assign a DRG using the combined diagnosis codes.	2
				Unable to calculate DRG (DRG 469)	2
				Unable to calculate DRG (DRG 470)	2
				DRG not on file.	2
				Diagnosis claim has maternity diagnosis and nursery charges	2
				Newborn DRG and maternity or emergency room charges.	2
				Date of service is after expiration date of current grouper tape.	2

B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.			Provider not certified/eligible to be paid for procedures on date(s) of service.	3
				Provider not enrolled for this category of service. If Medicare/provider ineligible for category of service.	3
				Provider enrollment file is closed by request, inactivity, change of location or tax ID#.	3
				Provider ineligible on date of service. Call provider enrollment to correct.	3
				Provider suspended from T-19 eligibility.	3
				Enrollment record deleted.	3
				Laboratory not eligible to provide service.	3
				Laboratory provider not on file.	3
				Provider ineligible on date of service, resubmit claim with EOMB attached.	3
				Nursing home can not admit - under sanction.	3
				Provider is not authorized for level of care on this TAD.	3
				Claim denied for enrollment criteria review - contact provider enrollment.	3
				Provider not paneled with U of U School of Dentistry on Date(s) of Service.	3
				Provider sanctioned for this procedure. Please contact state sanctioning agency.	3
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N570	Missing/incomplete/invalid credentialing data.	These services limited to specific providers	3
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95	This provider type/provider specialty may not bill this service.	Procedure to provider specialty conflict.	3
				Provider not eligible to bill service or recipient does not reside in an eligible county.	3
B8	Alternative services were available, and should have been utilized.			Use lower cost alternative.	3
B9	Patient is enrolled in a Hospice.			Service covered by hospice agency. Please rebill with correct information.	3
				Hospice/Nursing Home Conflict to Hospice - Service paid through another provider	3
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			Extraction of this tooth has been billed with procedure code Y0508. Review past payments.	3
				Dates of service are the same or overlap an already paid claim.	3
				Medicaid has paid for these services.	3
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	M86	Service denied because payment already made for same/similar procedure within set time frame.	Paid History Claim for Wheelchair Accessory.	3
				Exceeds residential services per month limit.	3
				Service has unit limit or there is a record of previous payment for this service.	3
				ICF possible duplicate	3
				Service was paid same or different location - see remittance advice information.	3
				ICF possible claim conflict	3
				These services have been paid for by Medicare.	3
				Duplicate procedure on claim exceeds unit limit.	3
B14	Only one visit or consultation per physician per day is covered.			Only 1 neonatal physician visit per day is covered.	3
				Service is limited to one critical care Phys. Evaluation & management per day.	3
				One physician visit per day.	3
				I.H.S. services are limited to one all inclusive rate per day for the same client, dos and provider.	3
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.			Procedure requires well child visit.	3
				Cannot bill procedure code alone, must bill along with an approved encounter code.	3
				Bill HCPC Codes, cannot bill T1015 Alone	3
				Paid outpatient physician claim.	3

B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	N674	Not covered unless a pre-requisite procedure/service has been provided.	Outpatient code editor has posted #84 or #85 and MMIS crosswalks to MMIS Edit 995.	3
B16	New Patient' qualifications were not met.			COG service not a new patient	3
				Not new patient/same specialty in group	3
				Claim/service adjusted because new patient qualificiation were not met.	3
B16	New Patient' qualifications were not met.	M86	Service denied because payment already made for same/similar procedure within set time frame.	Client received services from provider within previous 3 years. Bill established patient code.	3
B16	New Patient' qualifications were not met.	N113	Only one initial visit is covered per physician, group practice or provider.	Client has been billed as a new patient previously. Bill as an established patient.	3
				Client is not a new patient. Bill with established patient home medical care service procedure code	3
				Client is not a new patient. Bill as an established patient for NH custodial care service.	3
				Client is not a new patient. Bill with established patient code for long term care.	3
				Client received services from provider within previous 3 years. Bill established patient code.	3
				Client is not a new patient. Bill as established patient for emergency department services.	3
				Exceeds one initial dental examination per lifetime for this client.	3
B20	Procedure/service was partially or fully furnished by another provider.			Services provided by Weber Dental Clinic - see MIB 91-57	3
				Client received services at Weber Dental within last 30 days. Refer to MIB 91-57.	3
				Possible duplicate service by multiple providers	3