MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0201	BILLING PROVIDER ID NUMBER MISSING	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	85	BILLING PROVIDER
0202	BILLING PROVIDER ID IN INVALID FORMAT	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	85	BILLING PROVIDER
0203	MEMBER I.D. NUMBER MISSING/INVALID	26	ENTITY NOT FOUND	QC	PATIENT
0204	HOSPITAL DISCHARGE DATE INVALID	190	HOSPITAL DISCHARGE DATE	-	-
0205	PRESCRIBING PRACTITIONER S LICENSE NO. MISSING	142	ENTITY'S LICENSE/CERTIFICATION NUMBER	1T	PHYSICIAN, CLINIC OR GROUP PRACTICE
0206	PRESCRIBING PRACTITIONR LICENSE NO. FORMAT INVALID	142	ENTITY'S LICENSE/CERTIFICATION NUMBER	1T	PHYSICIAN, CLINIC OR GROUP PRACTICE
0208	PREGNANCY INDICATOR INVALID	254	PRIMARY DIAGNOSIS CODE	-	-
0210	BRAND MEDICALLY NECESSARY INDICATOR INVALID	382	DID PROVIDER AUTHORIZE GENERIC OR BRAND NAME DISPENSING?	-	-
0211	REFILL INDICATOR INVALID	403	ENTITY REFERRAL NOTES/ORDERS/PRESCRIPTION	85	BILLING PROVIDER
0212	PRESCRIPTION NUMBER IS MISSING	219	PRESCRIPTION NUMBER	-	-
0213	DATE PRESCRIBED IS MISSING	214	ORIGINAL DATE OF PRESCRIPTION/ORDERS/REFERRAL	-	-
0214	DATE PRESCRIBED IS INVALID	214	ORIGINAL DATE OF PRESCRIPTION/ORDERS/REFERRAL	-	-
0215	DATE DISPENSED IS MISSING	214	ORIGINAL DATE OF PRESCRIPTION/ORDERS/REFERRAL	-	-
0216	DATE DISPENSED IS INVALID	214	ORIGINAL DATE OF PRESCRIPTION/ORDERS/REFERRAL	-	-
0217	NDC MISSING	218	NDC NUMBER	-	-
0218	NDC INVALID FORMAT	218	NDC NUMBER	-	-
0219	QUANTITY DISPENSED IS MISSING	403	ENTITY REFERRAL NOTES/ORDERS/PRESCRIPTION	-	-
0220	QUANTITY DISPENSED IS INVALID	403	ENTITY REFERRAL NOTES/ORDERS/PRESCRIPTION	-	-
0221	DAYS SUPPLY MISSING	723	DRUG DAYS SUPPLY	-	-
0222	DAYS SUPPLY INVALID	723	DRUG DAYS SUPPLY	-	-
0223	PROC CODE REQUIRES DIAGNOSIS CODE, NONE FOUND ON CLAIM	255	DIAGNOSIS CODE	-	-
0224	DIAGNOSIS TREATMENT INDICATOR INVALID	477	DIAGNOSIS CODE POINTER IS MISSING OR INVALID	-	-
0225	MISSING PRESCRIBING PROVIDER NUMBER	153	ENTITY'S ID NUMBER	1P	PROVIDER
0226	REFERRAL PROV ID REQUIRED FOR PROCEDURE GROUP	132	ENTITY'S MEDICAID PROVIDER ID	DN	REFERRING PROVIDER
0227	THIRD PARTY PAYMENT AMOUNT INVALID	182	ALLOWABLE/PAID FROM OTHER ENTITIES COVERAGE	P4	PRIOR INSURANCE CARRIER
0228	BILLING PROVIDER SIGNATURE MISSING	466	ENTITIES ORIGINAL SIGNATURE	85	BILLING PROVIDER
0229	SOURCE OF ADMISSION MISSING	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	T4	TRANSFER POINT - USED TO IDENTIFY THE GEOGRAPHIC LOCATION WHERE A PATIENT IS TRANSFERRED
0231	RENDERING PROVIDER NUMBER IS MISSING	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	SJ	SERVICE PROVIDER
0233	UNITS OF SERVICE MISSING	476	MISSING OR INVALID UNITS OF SERVICE	-	-
0234	PROCEDURE CODE MISSING	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0235	PROCEDURE CODE NOT IN VALID FORMAT	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
0236	DETAIL DOS DIFFERENT THAN THE HEADER DOS	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0237	OUTPATIENT CLAIMS CANNOT SPAN DATES	188	STATEMENT FROM-THROUGH DATES	-	-
0238	MEMBER NAME IS MISSING	125	ENTITY'S NAME	IL	INSURED OR SUBSCRIBER
0239	THE DETAIL "TO" DATE OF SERVICE IS MISSING	187	DATE(S) OF SERVICE	-	-
0240	THE DETAIL "TO" DATE IS INVALID	187	DATE(S) OF SERVICE	-	-
0241	ACCIDENT INDICATOR IS INVALID	365	IS SERVICE THE RESULT OF AN ACCIDENT?	-	-
0242	SECONDARY DIAGNOSIS CODE INVALID FORMAT	255	DIAGNOSIS CODE	-	-
0243	MISSING MEDICARE PAID DATE	554	DATE CLAIM PAID	-	-
0244	THIRD DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-
0245	MISSING OCCURRENCE CODE	719	NUBC OCCURRENCE CODE(S)	-	-
0246	FOURTH DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-
0248	PLACE OF SERVICE IS MISSING OR BLANK	249	PLACE OF SERVICE	-	-
0249	PLACE OF SERVICE IS INVALID	249	PLACE OF SERVICE	-	-
0250	CLAIM HAS NO DETAILS	123	ADDITIONAL INFORMATION REQUESTED FROM ENTITY	IN	INSURER
0251	FIRST MODIFIER NOT COVERED	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
0252	SECOND MODIFIER NOT COVERED	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
0253	THIRD MODIFIER NOT COVERED	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
0254	BILLING PROVIDER LOCATION CODE MISSING	249	PLACE OF SERVICE	85	BILLING PROVIDER
0255	BILLING PROVIDER LOCATION CODE INVALID	249	PLACE OF SERVICE	85	BILLING PROVIDER
0256	MISSING MEDICARE PAID DATE - DETAIL	554	DATE CLAIM PAID	-	-
0257	PLACE OF SERVICE IS INVALID - DETAIL	249	PLACE OF SERVICE	-	-
0258	PRIMARY DIAGNOSIS CODE MISSING	254	PRIMARY DIAGNOSIS CODE	-	-
0259	DATE BILLED IS MISSING/INVALID	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0260	UNITS OF SERVICE NOT IN VALID FORMAT	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
0261	TOOTH NUMBER MISSING	244	TOOTH NUMBER OR LETTER	-	-
0262	TOOTH NUMBER INVALID	244	TOOTH NUMBER OR LETTER	-	-
0263	TOOTH SURFACE CODE INVALID	240	TOOTH SURFACE(S) INVOLVED	-	-
0264	DETAIL FROM DATE OF SERVICE IS MISSING	187	DATE(S) OF SERVICE	-	-
0265	DETAIL FROM DATE OF SERVICE IS INVALID	187	DATE(S) OF SERVICE	-	-
0266	INSUFFICIENT NUMBER OF VALID TOOTH SURFACE CODES	240	TOOTH SURFACE(S) INVOLVED	-	-
0268	BILLED AMOUNT MISSING	178	SUBMITTED CHARGES	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0269	DETAIL BILLED AMOUNT INVALID	178	SUBMITTED CHARGES	-	-
0270	HEADER TOTAL BILLED AMOUNT MISSING	178	SUBMITTED CHARGES	-	-
0271	HEADER TOTAL BILLED AMOUNT INVALID	178	SUBMITTED CHARGES	-	-
0272	PRIMARY DIAGNOSIS CODE INVALID	254	PRIMARY DIAGNOSIS CODE	-	-
0273	TYPE OF BILL MISSING	228	TYPE OF BILL FOR UB-92 CLAIM	-	-
0274	TYPE OF BILL CODE INVALID	228	TYPE OF BILL FOR UB-92 CLAIM	-	-
0275	ADMIT DATE MISSING	189	HOSPITAL ADMISSION DATE	-	-
0276	ADMIT DATE INVALID	189	HOSPITAL ADMISSION DATE	-	-
0277	ADMIT HOUR INVALID	230	HOSPITAL ADMISSION HOUR	-	-
0278	ADMIT TYPE MISSING	231	HOSPITAL ADMISSION TYPE	-	-
0279	INVALID TYPE OF ADMISSION	231	HOSPITAL ADMISSION TYPE	-	-
0280	PATIENT STATUS IS MISSING	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	QC	PATIENT
0281	PATIENT STATUS IS INVALID	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	QC	PATIENT
0282	COVERED DAYS MISSING	456	COVERED DAY(S)	-	-
0283	COVERED DAYS INVALID	456	COVERED DAY(S)	-	-
0284	PRIMARY CONDITION CODE INVALID	460	NUBC CONDITION CODE(S)	-	-
0285	SECOND CONDITON CODE INVALID	460	NUBC CONDITION CODE(S)	-	-
0286	THIRD CONDITION CODE INVALID	460	NUBC CONDITION CODE(S)	-	-
0287	FOURTH CONDITION CODE INVALID	460	NUBC CONDITION CODE(S)	-	-
0288	FIFTH CONDITION CODE INVALID	460	NUBC CONDITION CODE(S)	-	-
0289	SIXTH CONDITION CODE INVALID	460	NUBC CONDITION CODE(S)	-	-
0290	SEVENTH CONDITION CODE INVALID	460	NUBC CONDITION CODE(S)	-	-
0291	REVENUE CODE 183 REQUIRES OSC = 74	455	REVENUE CODE FOR SERVICES RENDERED	-	-
0292	REVENUE CODE 185 REQUIRES OSC = 71	455	REVENUE CODE FOR SERVICES RENDERED	-	-
0339	REVENUE CODE IS MISSING	455	REVENUE CODE FOR SERVICES RENDERED	-	-
0340	REVENUE CODE IS INVALID	455	REVENUE CODE FOR SERVICES RENDERED	-	-
0343	CERTIFICATION CODE INVALID	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
0347	PAYER PRIOR PAYMENT IS INVALID	286	OTHER PAYER'S EXPLANATION BENEFITS/PAYMENT INFO	-	-
0350	NO. OF DETAILS NOT EQUAL TO SUBMITTED DETAIL COUNT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0351	REFILL NOT ALLOWED FOR NARCOTIC DRUGS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0355	FIFTH DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-
0356	SIXTH DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0357	SEVENTH DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-
0358	EIGHTH DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-
0359	NINTH DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-
0360	TENTH DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-
0361	ELEVENTH DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-
0362	TWELFTH DIAGNOSIS CODE INVALID	255	DIAGNOSIS CODE	-	-
0363	PRINCIPAL ICD9 PROCEDURE CODE IS INVALID	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0365	PRINCIPAL PROCEDURE DATE INVALID	486	PRINCIPLE PROCEDURE DATE	-	-
0366	FIRST OTHER PROCEDURE CODE INVALID	490	OTHER PROCEDURE CODE FOR SERVICE(S) RENDERED	-	-
0368	FIRST OTHER PROCEDURE DATE INVALID	492	OTHER PROCEDURE DATE	-	-
0369	SECOND OTHER PROCEDURE CODE INVALID	490	OTHER PROCEDURE CODE FOR SERVICE(S) RENDERED	-	-
0371	SECOND OTHER PROCEDURE DATE INVALID	492	OTHER PROCEDURE DATE	-	-
0372	THIRD OTHER PROCEDURE CODE INVALID	490	OTHER PROCEDURE CODE FOR SERVICE(S) RENDERED	-	-
0375	FOURTH OTHER PROCEDURE CODE INVALID	490	OTHER PROCEDURE CODE FOR SERVICE(S) RENDERED	-	-
0378	FIFTH OTHER PROCEDURE CODE INVALID	490	OTHER PROCEDURE CODE FOR SERVICE(S) RENDERED	-	-
0382	ATTENDING PHYSICIAN ID INVALID	153	ENTITY'S ID NUMBER	71	ATTENDING PHYSICIAN
0383	FIRST OTHER PHYSICIAN ID INVALID	153	ENTITY'S ID NUMBER	73	OTHER PHYSICIAN
0389	REVENUE CODE REQUIRES A CORRESPONDING HCPCS/CPT4	507	HCPCS	-	-
0391	MEDICARE DEDUCTIBLE AMOUNT MISSING-DETAIL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0392	MEDICARE PAID AMOUNT NOT NUMERIC-DETAIL	655	TOTAL MEDICARE PAID AMOUNT	-	-
0393	MEDICARE DEDUCTIBLE AMOUNT MISSING	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0394	MEDICARE CO-INSURANCE AMOUNT MISSING	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0395	HEADER STATEMENT COVERS PERIOD "FROM" DATE MISSING	188	STATEMENT FROM-THROUGH DATES	-	-
0396	HEADER STATEMENT COVERS PERIOD "FROM" DATE INVALID	188	STATEMENT FROM-THROUGH DATES	-	-
0397	HEADER STMT COVERS PERIOD "THROUGH" DATE MISSING	188	STATEMENT FROM-THROUGH DATES	-	-
0398	STATEMENT COVERS PERIOD "THROUGH" DATE INVALID	188	STATEMENT FROM-THROUGH DATES	-	-
0400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	476	MISSING OR INVALID UNITS OF SERVICE	-	-
0401	PRESENT ON ADMISSION INDICATOR MISSING	688	PRESENT ON ADMISSION INDICATOR FOR REPORTED DIAGNOSIS CODES	-	-
0402	PRESENT ON ADMISSION INDICATOR INVALID	688	PRESENT ON ADMISSION INDICATOR FOR REPORTED DIAGNOSIS CODES	-	-
0403	PRESENT ON ADMISSION IND PRESENT WHERE NOT ALLOWED	688	PRESENT ON ADMISSION INDICATOR FOR REPORTED DIAGNOSIS CODES	-	-
0405	PAID PAPE WITH 0 ALLOWED UNITS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0427	ACCIDENT DATE INVALID	727	ACCIDENT DATE	-	-
0431	DEDUCTIBLE AMOUNT INVALID-DETAIL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0432	COINSURANCE AMOUNT INVALID-DETAIL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0433	MEDICARE DEDUCTIBLE AMOUNT INVALID	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0434	MEDICARE COINSURANCE AMOUNT INVALID	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0436	TOTAL MEDICARE ALLOWED AMOUNT INVALID	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0437	MEDICARE PSYCH ADJUSTMENT AMOUNT INVALID	519	ADJUSTMENT AMOUNT	-	-
0438	TOTAL MEDICARE ALLOWED AMOUNT INVALID-DETAIL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0439	PSYCH ADJUSTMENT (PR122) AMOUNT INVALID-DETAIL	519	ADJUSTMENT AMOUNT	-	-
0440	MCARE PAID 100% OF CLAIM-HEADER	591	MEDICARE PAID AT 100% AMOUNT	-	-
0441	MCARE PAID 100% OF CLAIM-DETAIL	591	MEDICARE PAID AT 100% AMOUNT	-	-
0442	MEDICARE PAID AMOUNT NOT NUMERIC-HEADER	182	ALLOWABLE/PAID FROM OTHER ENTITIES COVERAGE	P4	PRIOR INSURANCE CARRIER
0443	MEDICARE PAID AMOUNT NOT NUMERIC-DETAIL	182	ALLOWABLE/PAID FROM OTHER ENTITIES COVERAGE	P4	PRIOR INSURANCE CARRIER
0444	MEDICARE APPROVED AMOUNT = 0 - HEADER	655	TOTAL MEDICARE PAID AMOUNT	-	-
0445	MEDICARE APPROVED AMOUNT = 0 - DETAIL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0450	INVALID QUADRANT	242	TOOTH NUMBERS, SURFACES, QUADRANTS INVOLVED	-	-
0452	DTL RENDERING/PERFORMING PROVIDER SERV LOC MISSING	138	ENTITY'S SITE ID	82	RENDERING PROVIDER
0453	HDR RENDERING/PERFORMING PROVIDER SERV LOC MISSING	138	ENTITY'S SITE ID	82	RENDERING PROVIDER
0454	INVALID ASSIGNMENT CODE	360	BENEFITS ASSIGNMENT CERTIFICATION INDICATOR	-	-
0456	INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER	250	TYPE OF SERVICE	-	-
0457	INVALID PRINCIPAL/OTHER PROCEDURE TYPE	250	TYPE OF SERVICE	-	-
0458	DIAGNOSIS CODE 10 - 24 INVALID	255	DIAGNOSIS CODE	-	-
0459	DETAIL DIAGNOSIS TREATMENT INDICATOR INVALID	658	TREATMENT CODE	-	-
0461	VALUE CODE IS INVALID	725	NUBC VALUE CODE(S)	-	-
0462	VALUE CODE AMOUNT IS MISSING	725	NUBC VALUE CODE(S)	-	-
0463	VALUE CODE AMOUNT IS INVALID	725	NUBC VALUE CODE(S)	-	-
0471	CONDITION CODE 8-24 INVALID	460	NUBC CONDITION CODE(S)	-	-
0473	ICD9 PROCEDURE 7-24 INVALID	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0474	ICD-9 PROCEDURE 7-24 OR DATE MISSING	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0475	ICD9 PROCEDURE 7-24 DATE IS INVALID	492	OTHER PROCEDURE DATE	-	-
0476	DETAIL ATTENDING PHYSICIAN ID IS INVALID	153	ENTITY'S ID NUMBER	71	ATTENDING PHYSICIAN
0477	DETAIL FIRST "OTHER PHYSICIAN" ID IS INVALID	153	ENTITY'S ID NUMBER	72	OPERATING PHYSICIAN

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0478	0478-BILL CPT CODES TO MASSHEALTH ON CMS 1500 FORM	276	UB-92/HCFA-1450/HCFA-1500 CLAIM FORM	-	-
0481	MLOA DAYS GREATER THAN HEADER DAYS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0484	LOA OSC DATES CANNOT SPAN ACROSS DIFFERENT MONTHS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0485	TO DATE IS LESS THAN FROM DATE FOR OCCUR SPAN	722	NUBC OCCURRENCE SPAN CODE DATE(S)	-	-
0486	MLOA DAYS AND DAYS BETWEEN FROM AND TO DOS NOT EQUAL	188	STATEMENT FROM-THROUGH DATES	-	-
0487	NMLOA DAYS AND DAYS TWEEN FROM AND TO DOS NOT SAME	188	STATEMENT FROM-THROUGH DATES	-	-
0488	MLOA OSC DAYS SPANNED > DETAIL FROM AND TO DOS	188	STATEMENT FROM-THROUGH DATES	-	-
0489	THE OCCURRENCE SPAN FROM DATE IS INVALID	722	NUBC OCCURRENCE SPAN CODE DATE(S)	-	-
0490	THE OCCURRENCE SPAN TO DATE IS INVALID	722	NUBC OCCURRENCE SPAN CODE DATE(S)	-	-
0491	DIFFERNT MLOA DAYS CANNOT OVERLAP FROM AND TO DAYS	187	DATE(S) OF SERVICE	-	-
0492	DIFFERNT NMLOA DAYS CANT OVERLAP FROM AND TO DAYS	187	DATE(S) OF SERVICE	-	-
0493	MLOA AND NMLOA DAYS CANT OVERLAP FROM AND TO DAYS	187	DATE(S) OF SERVICE	-	-
0494	OCCURRENCE SPAN LOA DATES NOT WITHIN CLAIM DATES	722	NUBC OCCURRENCE SPAN CODE DATE(S)	-	-
0495	THIS LTC CLAIM HAS LOA DAYS, BUT PROV TYPE WRONG	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0496	OCCURRENCE SPAN FROM DATE MISSING	722	NUBC OCCURRENCE SPAN CODE DATE(S)	-	-
0497	OCCURRENCE SPAN TO DATE MISSING	722	NUBC OCCURRENCE SPAN CODE DATE(S)	-	-
0498	THE OCCURRENCE CODE IS INVALID	719	NUBC OCCURRENCE CODE(S)	-	-
0500	DATE PRESCRIBED AFTER BILLING DATE	214	ORIGINAL DATE OF PRESCRIPTION/ORDERS/REFERRAL	-	-
0502	DATE DISPENSED EARLIER THAN DATE PRESCRIBED	214	ORIGINAL DATE OF PRESCRIPTION/ORDERS/REFERRAL	-	-
0503	DATE DISPENSED AFTER BILLING DATE	214	ORIGINAL DATE OF PRESCRIPTION/ORDERS/REFERRAL	-	-
0506	ICN DATE PRIOR TO DATE BILLED	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0507	THE DETAIL "FROM" DATE IS AFTER THE "TO" DATE	188	STATEMENT FROM-THROUGH DATES	-	-
0508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS	178	SUBMITTED CHARGES	-	-
0509	NET BILLED OUT OF BALANCE	400	CLAIM IS OUT OF BALANCE	-	-
0512	CLAIM PAST 12 MONTH FILING LIMIT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0514	HEADER THRU DATE OF SERVICE AFTER ICN DATE	187	DATE(S) OF SERVICE	-	-
0518	COVERED DAYS EXCEED STATEMENT PERIOD	456	COVERED DAY(S)	-	-
0519	ADMIT DATE IS AFTER STATEMENT PERIOD "FROM" DATE	187	DATE(S) OF SERVICE	-	-
0520	INVALID REVENUE CODE/PROCEDURE CODE COMBINATION	455	REVENUE CODE FOR SERVICES RENDERED	-	-
0521	THRU DOS LATER THAN DISCHARGE DATE	187	DATE(S) OF SERVICE	-	-
0526	HEADER FROM DOS IS AFTER HEADER THROUGH DATE	187	DATE(S) OF SERVICE	-	-
0527	DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE	187	DATE(S) OF SERVICE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0529	SURGERY DATE IS BEFORE THE ADMIT DATE	665	SURGERY DATE	-	-
0530	SURGERY DATE IS AFTER THE DISCHARGE DATE	665	SURGERY DATE	-	-
0532	REVENUE CODE/PROVIDER SPECIALTY MISMATCH	455	REVENUE CODE FOR SERVICES RENDERED	-	-
0542	MEMBER INELIGIBLE SERV DATE	88	ENTITY NOT ELIGIBLE FOR BENEFIT FOR SUBMITTEDDATES OF SERVICE	IL	INSURED OR SUBSCRIBER
0545	FINAL DEADLINE EXCEEDED	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0550	ADJUSTMENT FAILED	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0551	DISPOSITION AMT FOR ADJUSTMENT IS LESS THAN ZERO	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0552	PROVIDER MAY NOT ADJUST GENERATED ATP/PAPE CLAIM	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0554	HEADER BILLED DATE IS PRIOR TO DATES OF SERVICE	187	DATE(S) OF SERVICE	-	-
0555	CLAIM PAST 24 MONTH FILING DEADLINE- DETAIL	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0556	CLAIM PAST 24 MONTH FILING DEADLINE- HEADER	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0557	COINS AND DEDUCT AMT MISSING - DTL	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0558	COINSURANCE AND DEDUCT AMT MISSING	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0559	M-CARE COIN AMT GREATER THAN M-CARE PAID AMT-HDR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0560	M-CARE COINSURANCE AMT GREATER THAN THE AMOUNT PAID	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0568	HEADER DISCHARGE DATE IS LESS THAN ADMIT DATE	190	HOSPITAL DISCHARGE DATE	-	-
0569	HDR DTE OF ACCIDENT GREATER THAN LAST DTE OF SERV	727	ACCIDENT DATE	-	-
0570	HEADER TOTAL DAYS LESS THAN COVERED DAYS	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
0571	DETAIL SURGICAL PROCEDURE MISSING	666	SURGICAL PROCEDURE CODE	-	-
0572	ROOM AND BOARD DAYS CONFLICT	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
0574	SERV DATES ARE NOT IN SAME MONTH-HEADER	188	STATEMENT FROM-THROUGH DATES	-	-
0575	SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE	187	DATE(S) OF SERVICE	-	-
0576	CLAIM HAS THIRD-PARTY PAYMENT	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0577	SERV DATES ARE NOT IN SAME MONTH-DETAIL	187	DATE(S) OF SERVICE	-	-
0585	ADMIT DATE NOT EQ TO 1ST DATE OF SERV FOR REV/DIAG COMB	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0589	SUSPEND ADJUSTMENT FOR REVIEW	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0590	DAYS OVERLAPP FISCAL YEAR END/BEGIN DATES	188	STATEMENT FROM-THROUGH DATES	-	-
0594	UNITS/DOS CONFLICT	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
0599	ATTACHMENT CONTROL NUMBER MISSING	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0600	UNITS NOT EQUAL TO QUADRANTS BILLED	242	TOOTH NUMBERS, SURFACES, QUADRANTS INVOLVED	-	-
0601	TEETH NOT BILLABLE WITH QUADRANTS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0602	UNITS NOT EQUAL TO TEETH BILLED	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0610	LOC NOT COMPATIBLE WITH LEAVE DAYS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0616	COMPONENT OF STAY EXCEEDED	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0617	MEMBER AGE/PROGRAM CONFLICT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0643	INVALID OTHER COVERAGE CODE	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
0700	MULTIPLE PRIMARY ENDOSCOPIC FAMILIES CANNOT BE BILLED	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0701	NO PRIMARY SURGICAL PROCEDURE INDICATED	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
0702	ENDOSCOPIC PRICE AMOUNT LESS THAN ZERO	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0703	ENDO FAMILY MIXED PRIMARY/SECONDARY	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0799	INVALID DISPENSE STATUS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0800	HCPCS REQUIRES NDC	218	NDC NUMBER	-	-
0801	SPECIAL HANDLING EDIT	41	SPECIAL HANDLING REQUIRED AT PAYER SITE	-	-
0802	SPECIAL HANDLING EDIT WITH CRITICAL ERROR	41	SPECIAL HANDLING REQUIRED AT PAYER SITE	-	-
0803	GENERIC SPECIAL HANDLING	41	SPECIAL HANDLING REQUIRED AT PAYER SITE	-	-
0804	GENERIC SPECIAL PAY	41	SPECIAL HANDLING REQUIRED AT PAYER SITE	-	-
0805	INVALID SPECIAL HANDLING CODE	41	SPECIAL HANDLING REQUIRED AT PAYER SITE	-	-
0806	NOTE REQUIRED FOR PREEMPTIVE ESC - DETAIL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0807	NOTE REQUIRED FOR PREEMPTIVE ESC - HEADER	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0808	CLERK ID REQUIRED FOR PREEMPTIVE ESC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0809	CLERK ID REQUIRED FOR PREEMPTIVE ESC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0810	INVALID SUBMITTER ID	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0811	INVALID SUBMITTER ID/BILLING PROVIDER COMBINATION	104	PROCESSED ACCORDING TO PLAN PROVISIONS	85	BILLING PROVIDER
0812	NO PCC SELECTED	93	ENTITY IS NOT SELECTED PRIMARY CARE PROVIDER	1P	PROVIDER
0813	SPECIAL PAY PRICED AT ZERO	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0814	HIC NUMBER NOT PRESENT ON CLAIM	33	SUBSCRIBER AND SUBSCRIBER ID NOT FOUND	-	-
0815	TYPE OF BILL MUST MATCH PATIENT STATUS	228	TYPE OF BILL FOR UB-92 CLAIM	-	-
0816	DISALLOW ROOM AND BOARD FOR LATE CHARGES	455	REVENUE CODE FOR SERVICES RENDERED	-	-
0817	INVALID DISCHARGE DATE	190	HOSPITAL DISCHARGE DATE	-	-
0818	SPCL HANDLING 90 DAY WAIVER	41	SPECIAL HANDLING REQUIRED AT PAYER SITE	-	-
0819	SUSPEND CLAIM FOR TPL REVIEW	52	INVESTIGATING EXISTENCE OTHER INSUR COVERAGE	-	-
0820	NDC GIVEN WITH NO/INVALID UNITS FOR HCPCS	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
0821	NDC GIVEN WITH NO/INVALID MEASUREMENT FOR HCPCS	659	UNIT OR BASIS OF MEASUREMENT CODE	-	-
0822	NDC GIVEN WITH NO/INVALID UNIT PRICE FOR HCPCS	644	SERVICE LINE RATE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0823	NO PCC SELECTED	107	PROCESSED ACCORDING TO CONTRACT PROVISIONS	-	-
0828	CLAIM/ APPEAL IS UNDER REVIEW	46	INTERNAL REVIEW/AUDIT	-	-
0829	NCCI APPEAL/SPECIAL HANDLE UNDER REVIEW	46	INTERNAL REVIEW/AUDIT	-	-
0830	GROUPER UNABLE TO ASSIGN DRG TO CLAIM	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0831	3M GRP - DIAGNOSIS CODE CANNOT BEUSED AS PRINCIPAL DIAGNOSIS	255	DIAGNOSIS CODE	-	-
0832	3M GRP - RECORD DOES NOT MEET CRITERIA FOR ANY DRG	256	DRG CODE(S)	-	-
0833	3M GRP - INVALID AGE IN YEARS OR ADMISSION AGE IN DAY	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0834	3M GRP - INVALID SEX	157	ENTITY'S GENDER	IL	INSURED OR SUBSCRIBER
0835	3M GRP - INVALID DISCHARGE STATUS	234	PATIENT DISCHARGE STATUS	-	-
0836	3M GRP - INVALID BIRTH WEIGHT	273	WEIGHT	-	-
0837	3M GRP - INVALID DISCHARGE AGE IN DAYS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0838	3M GRP - INVALID PRINCIPAL DIAGNOSIS	254	PRIMARY DIAGNOSIS CODE	-	-
0839	3M GRP - GESTATIONAL AGE/BIRTH WEIGHT CONFLICT	273	WEIGHT	-	-
0850	BILLING DEADLINE EXCEEDED - DETAIL	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0851	REBILL: ORIGINAL CLAIM DEADLINE EXCEEDED	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0852	BILLING DEADLINE EXCEEDED - HEADER	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0853	FINAL DEADLINE EXCEEDED - DETAIL	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0854	TIMELY FILING - ORIGINAL ICN NOT FOUND	559	DOCUMENT CONTROL IDENTIFIER	-	-
0855	FINAL DEADLINE EXCEEDED - HEADER	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0856	DATE OF SERVICE EXCEEDS 36 MONTHS - DETAIL	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0857	DATE OF SERVICE EXCEEDS 36 MONTHS - HEADER	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0861	MEMBER MUST APPLY BEFORE ADMIN DAYS START	91	ENTITY NOT ELIGIBLE/NOT APPROVED DATES OF SRV	QC	PATIENT
0862	EMERGENCY INDICATOR/POS MISMATCH	471	WERE SERVICES RELATED TO AN EMERGENCY?	-	-
0870	INVALID START/STOP TIME	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0871	VOID / ORIGINAL $ AMOUNT CONFLICT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0872	MONTH/YEAR MISMATCH ON ADJUSTMENT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0873	NDC SUBMITTED ON INVALID PROCEDURE	218	NDC NUMBER	-	-
0874	PRESCRIPTION INVALID FOR COMPOUND DRUG	282	COPY OF PRESCRIPTION	-	-
0875	PROCEDURE INVALID FOR COMPOUND DRUG	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
0876	INVALID PRODUCT QUALIFIER	218	NDC NUMBER	-	-
0877	INVALID PRESCRIPTION QUALIFIER	219	PRESCRIPTION NUMBER	-	-
0878	INVALID PRESCRIPTION QUALIFIER/ID COMBINATION	219	PRESCRIPTION NUMBER	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0879	INVALID PRESCRIPTION QUALIFIER/ID COMBINATION	219	PRESCRIPTION NUMBER	-	-
0880	INVALID PRESCRIPTION ID	219	PRESCRIPTION NUMBER	-	-
0881	INVALID PRESCRIPTION DATE	403	ENTITY REFERRAL NOTES/ORDERS/PRESCRIPTION	1P	PROVIDER
0882	PRESCRIPTION DATE GREATER THAN CLAIM DATE	214	ORIGINAL DATE OF PRESCRIPTION/ORDERS/REFERRAL	-	-
0886	ATTACHMENT REQUIRED-PODIATRIC, SUSPEND FOR REVIEW	297	MEDICAL NOTES/REPORTS	-	-
0888	DCN INVALID FOR ATTACHMENT CROSS-REFERENCE	559	DOCUMENT CONTROL IDENTIFIER	-	-
0889	CLAIM ATTACHMENT REQUIRED FOR PODIATRIC SERVICE	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
0890	EDI TRANS TYPE IS 31	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0891	EDI TRANS TYPE IS RP	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
0900	PROVIDER TYPE/SPEC GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0902	PROCEDURE CODE GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0903	OCCURRENCE CODE GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0904	VALUE CODE GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0905	REVENUE CODE GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0906	DIAGNOSIS GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0907	ICD-9 PROCEDURE GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0908	MODIFIER GROUP EMPTY	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
0909	PATIENT STATUS GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0910	BENEFIT PLAN GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0911	CLAIM IN PROCESS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0912	PROVIDER LOC GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0913	SPECIAL HANDLING GROUP EMPTY	41	SPECIAL HANDLING REQUIRED AT PAYER SITE	-	-
0914	TYPE OF BILL GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0915	COUNTY CODE GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0916	ZIP CODE GROUP EMPTY	500	ENTITY'S POSTAL/ZIP CODE	FE	MAIL ADDRESS
0917	PLACE OF SERVICE GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0918	MEMBER LOC GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0919	ESC GROUP EMPTY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
0930	2ND OCCURRENCE POSITION NOT = 22	719	NUBC OCCURRENCE CODE(S)	-	-
0931	2ND OCCURRENCE OCDE = 22 BUT AMOUNT = 0	719	NUBC OCCURRENCE CODE(S)	-	-
0932	2ND OCCURRENCE AMOUNT > 0 BUT OSC NOT 22	719	NUBC OCCURRENCE CODE(S)	-	-
0933	INP CLM BUT RATE ID NOT 71 OR ADM TYPE NE ELCTV[3]	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
0935	UB92 CLAIM BUT NO PATIENT ACCT NUMBER (MRN)	478	CLAIM SUBMITTER'S IDENTIFIER (PATIENT ACCOUNTNUMBER) IS MISSING	-	-
0936	MEMBER ENROL/PCCP CNFLCT	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
0937	DETAIL CANNOT SPAN DATES	188	STATEMENT FROM-THROUGH DATES	-	-
0999	CLAIM SELECTED FOR MASSPRO EXTRACT	99	PRE-TREATMENT REVIEW	-	-
1000	BILLING PROVIDER I.D. NUMBER NOT ON FILE.	26	ENTITY NOT FOUND	85	BILLING PROVIDER
1001	COB-BENEFIT PLAN	550	COORDINATION OF BENEFITS CODE	2B	THIRD-PARTY ADMINISTRATOR
1002	DTL PERFORMING PROVIDER NOT ELIGIBLE	550	COORDINATION OF BENEFITS CODE	2B	THIRD-PARTY ADMINISTRATOR
1003	BILLING PROV NOT ELIG AT SERV LOC FOR PROG BILLED	88	ENTITY NOT ELIGIBLE FOR BENEFIT FOR SUBMITTEDDATES OF SERVICE	85	BILLING PROVIDER
1007	DETAIL RENDERING PROVIDER I.D. NOT ON FILE	26	ENTITY NOT FOUND	SJ	SERVICE PROVIDER
1010	RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP	153	ENTITY'S ID NUMBER	82	RENDERING PROVIDER
1012	RENDERING PROV SPECLTY NOT ELIG TO RENDER PROCEDURE	145	ENTITY'S SPECIALTY CODE	82	RENDERING PROVIDER
1013	PROV ASSIGNMENT NOT ACCEPTED	589	MEDICARE ASSIGNMENT CODE	-	-
1014	INVALID ASSIGNMENT INDICATOR	589	MEDICARE ASSIGNMENT CODE	-	-
1018	PROVIDER RATE NOT ON FILE	499	NO RATE ON FILE WITH THE PAYER FOR THIS SERVICE FOR THIS ENTITY	1P	PROVIDER
1019	NO PROVIDER LEVEL OF CARE RATE ON FILE	499	NO RATE ON FILE WITH THE PAYER FOR THIS SERVICE FOR THIS ENTITY	1P	PROVIDER
1020	ATTENDING PHYSICIAN ID NOT ON FILE	26	ENTITY NOT FOUND	71	ATTENDING PHYSICIAN
1021	FIRST OTHER PHYSICIAN ID NOT ON FILE	153	ENTITY'S ID NUMBER	73	OTHER PHYSICIAN
1023	LEVEL OF CARE BILLED NOT ON FILE FOR THIS PROVIDER	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
1024	BILLING PROVIDER NOT LISTED AS MEMBER LTC PROV	91	ENTITY NOT ELIGIBLE/NOT APPROVED DATES OF SRV	85	BILLING PROVIDER
1026	PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE	142	ENTITY'S LICENSE/CERTIFICATION NUMBER	71	ATTENDING PHYSICIAN
1027	HEADER REFERRING PHYSICIAN ID NOT ON FILE	26	ENTITY NOT FOUND	DN	REFERRING PROVIDER
1032	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLM TYP	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	85	BILLING PROVIDER
1036	RENDERING PROVIDER NOT ELIGIBLE TO BILL THIS CLM TYPE	91	ENTITY NOT ELIGIBLE/NOT APPROVED DATES OF SRV	82	RENDERING PROVIDER
1037	FACILITY PROVIDER NUMBER NOT ON FILE	26	ENTITY NOT FOUND	2D	MISCELLANEOUS HEALTHCARE FACILITY
1040	BILLING PROVIDER ON REVIEW	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
1041	BILLING PROVIDER ON REVIEW	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
1050	SERVICE CANNOT BE REFERRED BY THE SAME BILLING PRO	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	85	BILLING PROVIDER
1051	HEADER RENDERING PROVIDER ID NOT VALID	26	ENTITY NOT FOUND	SJ	SERVICE PROVIDER
1053	DETAIL FIRST OTHER PHYSICIAN ID NUMBER NOT ON FILE	26	ENTITY NOT FOUND	73	OTHER PHYSICIAN
1054	DETAIL ATTENDING PHYSICIAN ID NUMBER NOT ON FILE	26	ENTITY NOT FOUND	71	ATTENDING PHYSICIAN

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
1055	DETAIL REFERRING PROV NOT ON FILE	26	ENTITY NOT FOUND	DN	REFERRING PROVIDER
1058	UNABLE TO CROSSWALK ATTENDING/OTHER1/OTHER2 MEDICARE PROVIDER ID	132	ENTITY'S MEDICAID PROVIDER ID	73	OTHER PHYSICIAN
1060	UNABLE TO CROSSWALK RENDERING MEDICARE PROVIDER ID	132	ENTITY'S MEDICAID PROVIDER ID	SJ	SERVICE PROVIDER
1062	UNABLE TO CROSSWALK DETAIL RENDERING MEDICARE PROV	26	ENTITY NOT FOUND	SJ	SERVICE PROVIDER
1063	UNABLE TO CROSSWALK BILLING MEDICARE PROVIDER ID	26	ENTITY NOT FOUND	85	BILLING PROVIDER
1064	HEADER REFERRING PROVIDER CANNOT BE SAME AS BILLIN	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	DN	REFERRING PROVIDER
1065	DETAIL REFERRING PROVIDER CANNOT BE SAME AS BILLING	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	DN	REFERRING PROVIDER
1066	BILLING PROVIDER NOT A VALID BILLER	91	ENTITY NOT ELIGIBLE/NOT APPROVED DATES OF SRV	85	BILLING PROVIDER
1067	RENDERING EQUALS BILLING AND NOT A VALID BILLER	132	ENTITY'S MEDICAID PROVIDER ID	SJ	SERVICE PROVIDER
1068	REFERRING PROVIDER REQUIRED FOR INDEPENDENT CERTIF	26	ENTITY NOT FOUND	DN	REFERRING PROVIDER
1069	REFERRING PROV CANNOT BE SAME AS RENDERING-HEADER	153	ENTITY'S ID NUMBER	DN	REFERRING PROVIDER
1070	REFERRING PROV CANNOT BE SAME AS RENDERING-DETAIL	153	ENTITY'S ID NUMBER	DN	REFERRING PROVIDER
1071	PATIENT STILL IN THE HOSPITAL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	QC	PATIENT
1073	BILLING PROVIDER OUT OF STATE CONTIGUOUS	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
1074	BILLING PROVIDER OUT OF STATE NON-CONTIGUOUS	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
1100	ADJUST: FORMER TCN INCORRECT	495	REQUESTS FOR RE-ADJUDICATION MUST REFERENCE THE NEWLY ASSIGNED PAYER CLAIM CONTROL NUMBER FOR THIS PREVIOUSLY ADJUSTED CLAIM. CORRECT THE PAYER CLAIM CONTROL NUMBER AND RE-SUBMIT	-	-
1101	INVALID ADJUSTMENT FORMER TCN	464	PAYER ASSIGNED CONTROL NUMBER	-	-
1104	REBILL : ORIGINAL CLAIM PAID	65	CLAIM/LINE HAS BEEN PAID	-	-
1108	THIS ADJUSTMENT CLAIM IS ALREADY ON HOLD	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
1111	ITEM/SERVICE(S) PROVIDED NOT MOST COST EFFECTIVE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISNS	-	-
1116	SHOE PRESCRIPTION FORM MISSING	294	SUPPORTING DOCUMENTATION	-	-
1117	PROC REQ REPORT/ RPT MISSING	295	ATTENDING PHYSICIAN REPORT	-	-
1119	BILLING RID CONFLICT	26	ENTITY NOT FOUND	QC	PATIENT
1120	CLAIM REQUIRES DOCUMENTATION (CAF EDIT)	295	ATTENDING PHYSICIAN REPORT	-	-
1121	STERILIZATION FORM INCOMPLETE	294	SUPPORTING DOCUMENTATION	-	-
1122	STERILIZATION REGS NOT MET	294	SUPPORTING DOCUMENTATION	-	-
1123	CLAIM NOT LEGIBLE	481	CLAIM/SUBMISSION FORMAT IS INVALID	-	-
1125	INCIDENTAL PROC NOT COVERED	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
1126	CHARGES NOT ITEMIZED	178	SUBMITTED CHARGES	-	-
1127	HYSTERECTOMY REGS NOT MET	294	SUPPORTING DOCUMENTATION	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
1130	INVALID STERILIZATION FORM	294	SUPPORTING DOCUMENTATION	-	-
1132	CLAIMS REQ SPECIAL HANDLING	41	SPECIAL HANDLING REQUIRED AT PAYER SITE	-	-
1134	UR LETTER NOT ACCEPTABLE	295	ATTENDING PHYSICIAN REPORT	-	-
1135	CLAIM CONTAINS MEDICARE PART B COVERED CHARGES	590	MEDICARE COVERAGE INDICATOR	-	-
1136	NOT AN ACCEPTABLE ATTACHMENT	295	ATTENDING PHYSICIAN REPORT	-	-
1139	INVALID ABORTION FORM	294	SUPPORTING DOCUMENTATION	-	-
1140	ABORTION FORM INCOMPLETE	294	SUPPORTING DOCUMENTATION	-	-
1146	DUPE PREPAY REVIEW CLAIM OR RESUBMISSION ERROR	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
1149	PA# NOT ON FILE	252	ENTITY'S AUTHORIZATION/CERTIFICATION NUMBER	1P	PROVIDER
1150	IDENT/DSCR PROC WHEN BILLING AN UNLISTED CODE	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
1151	COPAY EXEMPT - AGE	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
1152	ASST SURG NOT COV FOR PROC	154	RELATIONSHIP OF SURGEON & ASSISTANT SURGEON	-	-
1153	UR DENIED ADMISSION	435	NOTICE OF ADMISSION	-	-
1514	INCORRECT PROC CODE FOR SERVICE	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
1515	PROCEDURE CODE/ INVOICE CONFLICT (PHARM)	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
1516	INCORRECT REV CODE FOR SERV	455	REVENUE CODE FOR SERVICES RENDERED	-	-
1517	CLAIM MED NECESS FORM ERROR	294	SUPPORTING DOCUMENTATION	-	-
1518	SERVICE PROVIDED REQUIRES A MORE DETAILED REPORT	294	SUPPORTING DOCUMENTATION	-	-
1519	INAPPROPRIATE PROCEDURE CODE FOR SERVICE BILLED	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
1520	PAYMENT INCLUDED IN PRIMARY PROCEDURE	12	ONE OR MORE ORIGINALLY SUBMITTED PROCEDURE CODES HAVE BEEN COMBINED	-	-
1521	PAYMENT MADE TO ANOTHER PHYSICIAN	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
1522	REPORT NOT LEGIBLE	294	SUPPORTING DOCUMENTATION	-	-
1523	HYSTERECTOMY FORM INCOMPLETE	294	SUPPORTING DOCUMENTATION	-	-
1524	INVALID HYSTERECTOMY FORM	294	SUPPORTING DOCUMENTATION	-	-
1525	ABORTION REGS NOT MET	294	SUPPORTING DOCUMENTATION	-	-
1526	MEDICAL RECORD NOT SUBMITTED TO PREPAYMENT REVIEW	297	MEDICAL NOTES/REPORTS	-	-
1527	MED REC INCOMPLETE AS DETERMINED BY PREPAY REVIEW	297	MEDICAL NOTES/REPORTS	-	-
1528	MLOA DAYS NOT INDICATED ON CLAIM FORM	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
1530	INVALID PRESCRIBING PROV TRANS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
1662	BILLING PROVIDER I.D. NUMBER NOT 0N FILE	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	85	BILLING PROVIDER
1801	NEED REFERRING PROVIDER FOR RADIOLOGY SERVICE	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	DN	REFERRING PROVIDER
1802	MCARE PART B PRICED AT 0 FOR TOB 12X	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
1803	HOLD MCARE PART A CLAIMS WITH TOB 111 OR 114	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
1804	DENY CLAIM TYPE A WITH TOB 112 OR 113	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
1805	BILLING PROVIDER ID WAS TRANSLATED	153	ENTITY'S ID NUMBER	85	BILLING PROVIDER
1806	CROSSOVER PRICING PERFORMED - HEADER (PAY)	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
1807	CROSSOVER PRICING PERFORMED - DETAIL (PAY)	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
1808	UNABLE TO PERFORM CROSSOVER PRICING - HEADER (DENY)	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
1809	UNABLE TO PERFORM CROSSOVER PRICING - DETAIL (DENY)	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
1900	INVALID TAXONOMY CODE - BILLING PROVIDER	145	ENTITY'S SPECIALTY CODE	85	BILLING PROVIDER
1901	INVALID TAXONOMY CODE-HEADER PERFORMING PROVIDER	145	ENTITY'S SPECIALTY CODE	SJ	SERVICE PROVIDER
1906	INVALID TAXONOMY FOR PROVIDER TYPE/SPEC - BILLING	145	ENTITY'S SPECIALTY CODE	85	BILLING PROVIDER
1907	INVALID TAXONOMY FOR PROVIDER TYPE/SPEC - HEADER P	145	ENTITY'S SPECIALTY CODE	SJ	SERVICE PROVIDER
1912	TAXONOMY CODE MISSING - BILLING PROVIDER	145	ENTITY'S SPECIALTY CODE	85	BILLING PROVIDER
1913	TAXONOMY CODE MISSING - HEADER PERFORMING PROVIDER	145	ENTITY'S SPECIALTY CODE	SJ	SERVICE PROVIDER
1919	INVALID TAXONOMY CODE - DETAIL PERFORMING PROVIDER	145	ENTITY'S SPECIALTY CODE	SJ	SERVICE PROVIDER
1921	INVALID TAXONOMY FOR PROVIDER TYPE/SPEC - DETAIL P	145	ENTITY'S SPECIALTY CODE	SJ	SERVICE PROVIDER
1925	TAXONOMY CODE MISSING - DETAIL PERFORMING PROVIDER	145	ENTITY'S SPECIALTY CODE	SJ	SERVICE PROVIDER
1927	NPI REQUIRED HEALTHCARE=Y BILLING PROV	145	ENTITY'S SPECIALTY CODE	85	BILLING PROVIDER
1928	NPI REQUIRED HEALTHCARE=Y PERFORMING PROV	145	ENTITY'S SPECIALTY CODE	SJ	SERVICE PROVIDER
1929	NPI DEACTIVATION DUE TO FRAUD	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	1P	PROVIDER
1930	NPI DEACTIVATION DUE TO DEATH, DISBANDMENT, OR OTHER	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	1P	PROVIDER
1934	DTL NPI REQUIRED HEALTHCARE=Y PERFORMING PROV	145	ENTITY'S SPECIALTY CODE	SJ	SERVICE PROVIDER
1936	INVALID BILLING PROVIDER SPECIFIED	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	85	BILLING PROVIDER
1937	INVALID PERFORMING PROVIDER SPECIFIED	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	SJ	SERVICE PROVIDER
1943	INVALID DTL PERFORMING PROVIDER SPECIFIED	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	SJ	SERVICE PROVIDER
1945	MULT SAK PROV LOCS FOR BILLING PROV SPEC	249	PLACE OF SERVICE	85	BILLING PROVIDER
1946	MULT SAK PROV LOCS FOR PERFORMING PROV SPEC	249	PLACE OF SERVICE	SJ	SERVICE PROVIDER
1949	MULT SAK PROV LOCS FOR RENDERING PROV SPEC	249	PLACE OF SERVICE	SJ	SERVICE PROVIDER
1950	NPI SUBMISSION ERROR	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
1952	MULT SAK PROV LOCS FOR DTL PERFORM PROV SPEC	249	PLACE OF SERVICE	SJ	SERVICE PROVIDER
1954	BILLING PROV ID NOT NPI BUT THERE IS NPI ON FILE	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	85	BILLING PROVIDER
1960	BILLING PROVIDER ON REVIEW	46	INTERNAL REVIEW/AUDIT	85	BILLING PROVIDER
1961	RENDERING PROVIDER ON REVIEW - HEADER	46	INTERNAL REVIEW/AUDIT	SJ	SERVICE PROVIDER

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
1962	RENDERING PROVIDER ON REVIEW - DETAIL	46	INTERNAL REVIEW/AUDIT	SJ	SERVICE PROVIDER
1995	RENDER/DISPENS/PERFORM PROV ID IN OLD FORMAT - HDR	132	ENTITY'S MEDICAID PROVIDER ID	SJ	SERVICE PROVIDER
1997	UNABLE TO POPULATE DTL PERFORMING PROV ID WITH HDR	562	ENTITY'S NATIONAL PROVIDER IDENTIFIER (NPI)	SJ	SERVICE PROVIDER
1999	HEADER BILLING PROVIDER ID IN OLD FORMAT	132	ENTITY'S MEDICAID PROVIDER ID	85	BILLING PROVIDER
2000	INVALID SEX	57	PENDING COBRA INFORMATION REQUESTED	-	-
2001	MEMBER ID NUMBER NOT ON FILE	26	ENTITY NOT FOUND	QC	PATIENT
2002	MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE	88	ENTITY NOT ELIGIBLE FOR BENEFIT FOR SUBMITTEDDATES OF SERVICE	QC	PATIENT
2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE	88	ENTITY NOT ELIGIBLE FOR BENEFIT FOR SUBMITTEDDATES OF SERVICE	QC	PATIENT
2004	MULTIPLE AID CATEGORY CODES COVER HEADER SERVICE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
2005	MULTIPLE AID CATEGORY CODES COVER DETAIL SERVICE	105	CLAIM/LINE IS CAPITATED	-	-
2006	CLAIMS SUBMITTED WITH LEGACY MEMBER ID	132	ENTITY'S MEDICAID PROVIDER ID	IL	INSURED OR SUBSCRIBER
2007	QMB MEMBER- BILL MEDICARE FIRST	52	INVESTIGATING EXISTENCE OTHER INSUR COVERAGE	-	-
2008	MEMBER LEVEL OF CARE NOT ON FILE	21	MISSING OR INVALID INFORMATION	-	-
2011	PHARMCY MEDICAL/NON-MEDICAL SUPPL. AND ROUTINE DME	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2014	MENTAL HLTH/SUBSTANCE ABUSE ONLY, BILL PARTNERSHIP	116	CLAIM SUBMITTED TO INCORRECT PAYER	-	-
2017	MEMBER SERVICES COVERED BY MCO PLAN	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISNS	13	CONTRACTED SERVICE PROVIDER
2018	MEMBER IS INROLLED IN HOSPICE	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2037	MEMBER ID IS INACTIVE	56	AWAITING ELIGIBILITY DETERMINATION	QC	PATIENT
2041	MEMBER# ON CLAIM AND PA MISMATCH	26	ENTITY NOT FOUND	QC	PATIENT
2043	MEMBER IS ON REVIEW	46	INTERNAL REVIEW/AUDIT	QC	PATIENT
2044	CLAIM INDICATES MEMBER EXPIRED	159	ENTITY'S DATE OF DEATH	QC	PATIENT
2049	LTC/HOSPICE CONFLICT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2051	MEMBER NOT CODED FOR LTC	91	ENTITY NOT ELIGIBLE/NOT APPROVED DATES OF SRV	QC	PATIENT
2052	LEVEL OF CARE/AID CAT CONFLICT	91	ENTITY NOT ELIGIBLE/NOT APPROVED DATES OF SRV	QC	PATIENT
2053	LTC/CASE MIX CONFLICT	91	ENTITY NOT ELIGIBLE/NOT APPROVED DATES OF SRV	QC	PATIENT
2055	SUPPLEMENTAL ADULT SERVICE/LTC RECIPIENT CONFLICT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2056	MEMBER NOT CODED FOR CASEMIX	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2057	DOS SPAN MONTHS-FILE SEPARATE CLAIMS FOR EACH MNTH	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2500	MEMBER IS COVERED BY OTHER INSURANCE-PAY	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	QC	PATIENT
2501	MEMBER IS COVERED BY OTHER INSURANCE - PAY AND	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2502	MEMBER IS COVERED BY OTHER INSURANCE - DENY	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
2503	MEMBER IS COVERED BY OTHER INSURANCE - PAY & CHASE	52	INVESTIGATING EXISTENCE OTHER INSUR COVERAGE	-	-
2504	MEMBER IS COVERED BY OTHER INSURANCE - SUSPEND	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	QC	PATIENT
2505	MEMBER COVERED BY MEDICARE-DENY	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
2509	MEMBER COVERED BY MEDICARE B (PHARMACY) - PROVIDER SHOULD BILL THROUGH POPS	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	QC	PATIENT
2510	MEMBER MEDICAL SUPPORT BYPASS – DTL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2511	CANNOT DETERMINE TPL PRICING METHOD	0	CANNOT PROVIDE FURTHER STATUS ELECTRONICALLY	-	-
2512	DUPLICATE CAS AT HEADER AND DETAIL	639	RESPONSIBILITY AMOUNT	-	-
2513	TPL ADJUDICATION DATE NOT PRESENT- DETAIL	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2514	TPL ADJUDICATION DATE NOT PRESENT-HEADER	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2515	OTHER INSURER REQUIRES ADDITIONAL DATA	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	P4	PRIOR INSURANCE CARRIER
2516	MEDICAID IS ALWAYS FINAL PAYOR	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2517	TPL REVIEW - CLM/EOB DIFFER	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2518	OTHER PAYER HAS BUNDLED DETAILS	526	BUNDLED OR UNBUNDLED LINE NUMBER	P4	PRIOR INSURANCE CARRIER
2519	CLAIM POTENTIALLY COVERED BY MEDICARE	56	AWAITING ELIGIBILITY DETERMINATION	-	-
2520	MEMBER IS COVERED BY OTHER INSURANCE-PAY,HEADER	56	AWAITING ELIGIBILITY DETERMINATION	-	-
2521	MEMBER IS COVERED BY OTHER INSURANCE - PAY AND REPORT	56	AWAITING ELIGIBILITY DETERMINATION	-	-
2522	MEMBER IS COVERED BY OTHER INSURANCE - DENY (HDR)	56	AWAITING ELIGIBILITY DETERMINATION	-	-
2523	MEMBER IS COVERED BY OTHER INSURANCE - PAY (CHASE)	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2524	MEMBER IS COVERED BY OTHER INSURANCE - SUSPEND (HDR)	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2525	MEMBER COVERED BY MEDICARE - DENY (HDR)	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2526	ZERO TPL AMOUNT AND NO ADJ RSN CODE - HEADER	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2527	ZERO TPL AMOUNT AND NO ADJ RSN CODE-DETAIL	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2528	LTC - POTENTIAL MEDICARE IN FIRST 100 DAYS	590	MEDICARE COVERAGE INDICATOR	-	-
2529	TPL AT HEADER AND NOT AT DETAIL	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2530	INVALID TPL CARRIER CODE	479	OTHER CARRIER PAYER ID IS MISSING OR INVALID	P4	PRIOR INSURANCE CARRIER

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
2531	MCARE COVERAGE INDICATED ON CLAIM, NOT ON FILE	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2532	HEBREW REHAB LTC TPL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2533	CARRIER IS 000 AND TPL AMOUNT > 0 - HEADER	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2534	CARRIER IS 000 AND TPL AMOUNT > 0 -DETAIL	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2535	INCORRECT TPL BILLING	286	OTHER PAYER'S EXPLANATN BENEFITS/PAYMENT INFORMATION	-	-
2536	MCARE# ON CLAIM/FILE CONFLICT	479	OTHER CARRIER PAYER ID IS MISSING OR INVALID	-	-
2537	INVALID BUNDLED LINE NO ASSIGNED BY OTHER PAYER	526	BUNDLED OR UNBUNDLED LINE NUMBER	P4	PRIOR INSURANCE CARRIER
2540	MEDICARE PAID > MEDICAID ALLOWED - HEADER	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2541	MEDICARE PAID > MEDICAID ALLOWED - DETAIL	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2543	MEDICARE PAYMENT OR PATIENT RESPONSIBILITY IS > 0	286	OTHER PAYER'S EXPLANATN BENEFITS/PAYMENT INFORMATION	-	-
2544	BENEFITS EXHAUSTED REPRICING	705	REPRICED ALLOWED AMOUNT		
2545	HEADER AND DETAIL COB PAYMENTS DO NOT BALANCE	400	CLAIM IS OUT OF BALANCE	-	-
2546	DETAIL COB PAYMENTS DO NOT BALANCE	400	CLAIM IS OUT OF BALANCE	-	-
2547	HEADER COB PAYMENTS DO NOT BALANCE	400	CLAIM IS OUT OF BALANCE	-	-
2548	NON COVERED AMT IS NOT EQUAL TO BILLED	596	NON-COVERED CHARGE AMOUNT	-	-
2549	REMAINING PATIENT LIABILITY PRESENT AT HEADER	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2550	REMAINING PATIENT LIABILITY PRESENT AT DETAIL	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2551	CLAIM HAS NON-COVERED AMT, HDR IS NOT ELIGIBLE	596	NON-COVERED CHARGE AMOUNT	-	-
2553	DETAIL ADJUSTMENT REASON CODE IS NOT ON ARC XREF	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	P4	PRIOR INSURANCE CARRIER
2555	INVALID FILING INDICATOR/CARRIER COMBINATION	480	ENTITY'S CLAIM FILING INDICATOR	1P	PROVIDER
2556	LTC - POTENTIAL MEDICARE C IN FIRST 100 DAYS	590	MEDICARE COVERAGE INDICATOR	-	-
2557	LTC - POTENTIAL PRIVATE INSURANCE IN FIRST 100 DAYS	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2558	OTHER PAYER DENIAL ARC IS NOT ON TABLE - HEADER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
2559	OTHER PAYER DENIAL ARC IS NOT ON TABLE - DETAIL	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
2561	TPL DATA CONFLICT	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	P4	PRIOR INSURANCE CARRIER
2562	BENEFITS EXHAUSTED TPL REPRICING - DETAIL	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2563	DETAIL ADJUSTMENT REASON CODE IS NOT ON ARC XREF	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
2564	MEMBER HAS MEDICARE SUPP INS DTL				
2565	CLAIM REQUIRES TPL REVIEW	52	INVESTIGATING EXISTENCE OTHER INSUR COVERAGE	-	-
2566	MEMBER HAS MEDICARE SUPP INS	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
2567	INVALID SUBMITTER FOR COB CLAIM	24	ENTITY NOT APPROVED AS AN ELECTRONIC SUBMITTR	1P	PROVIDER
2568	CLAIM HAS NON-COVERED AMT, DTL IS NOT ELIGIBLE	596	NON-COVERED CHARGE AMOUNT	-	-
2569	MEMBER HAS SELF-REPORTED OTHER INSURANCE	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2580	DETAIL, PROFESSIONAL OVERRIDE EDIT	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2581	HEADER, INSTITUTIONAL OVERRIDE EDIT	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2582	DETAIL, INSTITUTIONAL OVERRIDE EDIT	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2583	NON COVERED AMT AND CAS PRESENT FOR PAYER	596	NON-COVERED CHARGE AMOUNT	-	-
2584	MEMBER MEDICAL SUPPORT BYPASS - HDR	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2585	EOB DATE AT HEADER AND DETAIL	286	OTHER PAYER'S EXPLANATN BENEFITS/PAYMENT INFO	-	-
2588	HEADER/COMMERCIAL/SUSPEND EDIT FROM THE TPL DENY TAB	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2589	HEADER/MEDICARE/SUSPEND EDIT FROM THE TPL DENY TAB	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2590	DETAIL/COMMERCIAL/PAY EDIT FROM THE TPL DENY TABLE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2591	DETAIL/MEDICARE/PAY EDIT FROM THE TPL DENY TABLE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2592	DETAIL/COMMERCIAL/DENY EDIT FROM THE TPL DENY TABLE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2593	DETAIL/MEDICARE/DENY EDIT FROM THE TPL DENY TABLE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2594	DETAIL/COMMERCIAL/SUSPEND EDIT FROM THE TPL DENY TABLE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2595	DETAIL/MEDICARE/SUSPEND EDIT FROM THE TPL DENY TABLE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2596	HEADER/COMMERCIAL/PAY EDIT FROM THE TPL DENY TABLE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2597	HEADER/MEDICARE/PAY EDIT FROM THE TPL DENY TABLE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2598	HEADER/COMMERCIAL/DENY EDIT FROM THE TPL DENY TABL	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2599	HEADER/MEDICARE/DENY EDIT FROM THE TPL DENY TABLE	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
2608	MEMBER LOCKED-IN TO SPECIFIC NDC	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2610	NON-COVERED DAYS > 0	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
2612	DMH OR DPH SUBCONTRACTOR NOT AUTHORIZED	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
2613	MANAGED CARE SERVICE	515	MANAGED CARE REVIEW	-	-
2614	MANAGED CARE SERVICE SHOULD BE PAID BY RMC	515	MANAGED CARE REVIEW	-	-
2615	SENIOR PHARMACY MUST BE BILLED THROUGH POPS	515	MANAGED CARE REVIEW	-	-
2616	SERV NOT REIMBURSABLE BY MED ASSISTANCE PROGRAM	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
2617	PROC CODE REQUIRES REVIEW OF REPORT	297	MEDICAL NOTES/REPORTS	-	-
2620	REVENUE CODE REQ REVIEW	455	REVENUE CODE FOR SERVICES RENDERED	-	-
2621	BILL EXTENDED BENEFITS	88	ENTITY NOT ELIGIBLE FOR BENEFIT FOR SUBMITTEDDATES OF SERVICE	QC	PATIENT
2622	SERVICE NOT AUTHORIZED BY HMO	515	MANAGED CARE REVIEW	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
2623	PREPAYMENT TECHNICAL DENIAL	46	INTERNAL REVIEW/AUDIT	-	-
2625	MODIFIER INAPPROPRIATE/INCORRECT FOR SERV BILLED	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
2626	REQUEST FOR 90 DAY WAIVER DENIED	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2627	SERVICE COVERED BY CASE MANAGER	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	6Y	CASE MANAGER
2628	PREPAYMENT FULL DENIAL	84	SERVICE NOT AUTHORIZED	-	-
2629	PREPAYMENT PARTIAL DENIAL	84	SERVICE NOT AUTHORIZED	-	-
2630	NO PAS APPROVAL FOUND IN PREPAYMENT	352	ENTITY'S AUTHORIZATION/CERTIFICATION NUMBER	X3	UTILIZATION MANAGEMENT ORGANIZATION
2631	MCARE/BILL ALLOW PAID CONFLICT	643	SERVICE LINE PAID AMOUNT	-	-
2632	BENEFIT CONFLICT	88	ENTITY NOT ELIGIBLE FOR BENEFIT FOR SUBMITTEDDATES OF SERVICE	QC	PATIENT
2633	PREPAY PREVIOUSLY APPROVED	54	DUPLICATE OF A PREVIOUSLY PROCESSED CLAIM/LINE		
2634	PREPAY PREVIOUSLY DENIED	84	SERVICE NOT AUTHORIZED		
2635	PREPAY DECISION OVERTURNED	54	DUPLICATE OF A PREVIOUSLY PROCESSED CLAIM/LINE		
2640	NO RESPONSE TO OUR CAF	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
2800	MEMBER NOT TIED TO HOSPICE ON DOS	249	PLACE OF SERVICE	-	-
2802	NO BENEFIT PROGRAM FOR MEMBER FOUND	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
2803	PROCEDURE IS AGE RESTRICTED	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
2804	PROCEDURE IS INVALID FOR PATIENT SEX	57	PENDING COBRA INFORMATION REQUESTED	-	-
2805	MULTIPLE PPA SEGMENTS ON MEMBER FILE	171	OTHER INSURANCE COVERAGE INFORMATION (HEALTH,LIABILITY, AUTO, ETC.)	-	-
2900	SPAD CLAIM HAS CONTIGUOUS AID CATEGORY COVERAGE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
3000	PER UNIT PRICE ON CLAIM DOES NOT MATCH PRIOR AUTH	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3001	PA NOT FOUND ON DATABASE	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3002	NDC REQUIRES PA	252	AUTHORIZATION/CERTIFICATION NUMBER	85	BILLING PROVIDER
3003	PROCEDURE CODE REQUIRES PA	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3004	INVALID PA/PASNUMBER	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3005	INVALID PA/PAS NUMBER	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3006	PA DOLLARS EXCEEDED	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3009	PA/PAS NUMBER NOT ON THE DATABASE	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3010	OUT OF STATE PROVIDER REQUIRES REVIEW	297	MEDICAL NOTES/REPORTS	-	-
3013	PA NUMBER NOT ON THE DATABASE	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3015	MODIFIER ON CLAIM AND PA MISMATCH	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3022	SELECT FOR MASSPRO PRE-PAYMENT REVIEW	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
3023	INVALID RATE ID/PYMNT TYPE COMBINATION	499	NO RATE ON FILE WITH THE PAYER FOR THIS SERVICE FOR THIS ENTITY	1P	PROVIDER
3024	LINE ITEM NOT FOUND FOR PAS NUMBER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
3025	MULTIPLE ACTIVE LINE ITEMS FOR PAS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
3026	PAS NOT FOUND ON DATABASE	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3027	INVALID PAS NUM	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3028	NOT ENOUGH UNITS ON PAS	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3029	MEMBER ID FOR CLAIM AND PAS DONT MATCH	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3030	ADMISSION DATE FOR CLAIM AND PAS DONT MATCH	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3031	PROVIDER ID FOR CLAIM AND PA/PAS DO NOT MATCH	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3032	PAS IS REQUIRED	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3033	PA/PAS IS NOT READY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
3034	DUPLICATE CLAIM IN PRE-PAYMENT REVIEW	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
3035	CLAIM SELECTED FOR PRE-PAYMENT REVIEW	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
3036	RANDOM PRE-PAYMENT REVIEW PROCESS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
3038	PAS NOT REVIEWED BY PRO	99	PRE-TREATMENT REVIEW	-	-
3039	PAS NOT APPROVED	0	CANNOT PROVIDE FURTHER STATUS ELECTRONICALLY	-	-
3040	SURGERY/ASSIST USING SAME SERV PROVIDER NUMBER	153	ENTITY'S ID NUMBER	82	RENDERING PROVIDER
3041	MEMBER# OR PROV# ON CLAIM AND PA MISMATCH	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3101	PA STATUS IS VOID	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3102	PA STATUS IS DENIED	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3103	PROCEDURE NOT ON PA	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3104	REVENUE CODE / PA CONFLICT	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3105	MEMBER# ON CLAIM AND PA MISMATCH	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3107	SERV DATE AFTER PA EXPIRED	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3108	PA INSUFFICIENT AVAIL UNITS	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3109	PA UNITS PRESENTLY EXHAUSTED	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3110	PA EXHUSTED - CANNOT BE USED IN PRICING	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
3111	PRIOR AUTH PROCEDURE/MODIFIER MISMATCH	453	PROCEDURE CODE MODIFIERS(S) FOR SERVICE(S) RENDERED	-	-
3120	REFERRAL REQUIRED ON CLAIM	252	ENTITY'S AUTHORIZATION/CERTIFICATION NUMBER	1P	PROVIDER
3121	REFERRAL NUMBER INVALID	252	ENTITY'S AUTHORIZATION/CERTIFICATION NUMBER	1P	PROVIDER
3122	NO MORE UNITS AVAILABLE ON REFERRAL	252	ENTITY'S AUTHORIZATION/CERTIFICATION NUMBER	1P	PROVIDER
3124	RENDERING PROVIDER DOES NOT MATCH REFERRAL AUTH	252	ENTITY'S AUTHORIZATION/CERTIFICATION NUMBER	1P	PROVIDER

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
3125	MEMBER IN CLAIM DOES NOT MATCH REFERRAL	252	ENTITY'S AUTHORIZATION/CERTIFICATION NUMBER	QC	PATIENT
3126	SERVICE DATE IS OUTSIDE REFERRAL AUTH	252	ENTITY'S AUTHORIZATION/CERTIFICATION NUMBER	1P	PROVIDER
3300	JCODE GIVEN WITH INVALID NDC	218	NDC NUMBER	-	-
3301	LTC CLAIM REQUIRES A PATIENT LIABILITY AMOUNT	639	RESPONSIBILITY AMOUNT	-	-
3302	UNABLE TO DETERMINE RATE ID	499	NO RATE ON FILE WITH THE PAYER FOR THIS SERVICE FOR THIS ENTITY	1P	PROVIDER
3303	INVALID PROCEDURE/TOOTH SURFACE COMBINATION	240	TOOTH SURFACE(S) INVOLVED	-	-
3304	MANUFACTURERS INVOICE REQUIRED	294	SUPPORTING DOCUMENTATION	-	-
3305	INVALID PATIENT PAY AMOUNT	639	RESPONSIBILITY AMOUNT	QC	PATIENT
3306	SPAD RATE NOT ALLOWED FOR TRANSFER PATIENT STATUS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
3307	NO PATIENT LIABILITY ON FILE OR ON THE CLAIM	639	RESPONSIBILITY AMOUNT	-	-
3310	CURRENT SUPPLIERS INVOICE REQUIRED	294	SUPPORTING DOCUMENTATION	-	-
3311	ACQUISTION COST MISSING	294	SUPPORTING DOCUMENTATION	-	-
3312	MAX FEE RELATIVE VALUE MUST BE > 0 ON DOS	523	ANESTHESIA UNIT COUNT	-	-
3314	POS, MODIFIER INVALID FOR RADIOLOGY	249	PLACE OF SERVICE	-	-
3315	ICD9-CM STERILIZATION PROC REQUIRES ATTACHMENT	294	SUPPORTING DOCUMENTATION	-	-
3316	ICD9-CM HYSTERECTOMY PROC REQUIRES ATTACHMENT	294	SUPPORTING DOCUMENTATION	-	-
3317	ICD9-CM ABORTION PROC REQUIRES ATTACHMENT	294	SUPPORTING DOCUMENTATION	-	-
3318	NON COVRD DAYS MUST BE NUMERIC FOR PROV TYPE 70/74	457	NON-COVERED DAY(S)	-	-
3319	BENEFIT PLAN AGE RESTRICTION ON PRIMARY DIAG	254	PRIMARY DIAGNOSIS CODE	-	-
3320	BENEFIT PLAN AGE RESTRICTION ON SECOND DIAG	255	DIAGNOSIS CODE	-	-
3321	BENEFIT PLAN AGE RESTRICTION ON THIRD DIAG	255	DIAGNOSIS CODE	-	-
3322	BENEFIT PLAN AGE RESTRICTION ON FOURTH DIAG	255	DIAGNOSIS CODE	-	-
3323	BENEFIT PLAN AGE RESTRICTION ON FIFTH DIAG	255	DIAGNOSIS CODE	-	-
3324	BENEFIT PLAN AGE RESTRICTION ON SIXTH DIAG	255	DIAGNOSIS CODE	-	-
3325	BENEFIT PLAN AGE RESTRICTION ON SEVENTH+ DIAG	255	DIAGNOSIS CODE	-	-
3326	BENEFIT PLAN AGE RESTRICTION ON ADMIT DIAG	232	ADMITTING DIAGNOSIS	-	-
3327	TYPE OF BILL CANNOT BE CROSS WALKED TO A PLACE OF SERVICE	228	TYPE OF BILL FOR UB-92 CLAIM	-	-
3335	NO VALID DERIVED RATE ID	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
3602	CLAIM AND EOB DIFFER	286	OTHER PAYER'S EXPLANATN BENEFITS/PAYMENT INFO	-	-
4001	BENEFIT PLAN BILL PR TYP RESTRICTION ON DIAGNOSIS	145	ENTITY'S SPECIALTY CODE	85	BILLING PROVIDER
4002	NDC INDICATES A NON-COVERED DRUG ON DOS	596	NON-COVERED CHARGE AMOUNT	-	-
4003	ATTACH REV ON STERIL/HYST DIAG	294	SUPPORTING DOCUMENTATION	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4004	NDC NOT ON FILE	218	NDC NUMBER	85	BILLING PROVIDER
4007	NON-COVERED NDC DUE TO CMS TERMINATION	219	PRESCRIPTION NUMBER	-	-
4009	ALLOWED AMOUNT LESS THAN DRUG CHARGE VARIANCE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	85	BILLING PROVIDER
4010	MODIFIER REQUIRES MEDICAL REVIEW	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
4011	INVALID MODIFIER/MODIFIER COMBINATION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4012	ABORTION PROCEDURE INDICATED	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4013	PROCEDURE CODE IS NOT COVERED FOR DATE OF SERVICE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4014	NO PRICING SEGMENT ON FILE	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
4015	MULTIPLE PRICING MODIFIERS ON CLAIM	628	PRICING METHODOLOGY	-	-
4016	BENEFIT PLAN PERF PR TYP RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4017	BENEFIT PLAN BILL PR TYP RESTRICTION ON DRG	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4018	BENEFIT PLAN PERF PR TYP RESTRICTION ON DRG	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4019	PROCEDURE CODE REQUIRES ATTACHMENT	294	SUPPORTING DOCUMENTATION	-	-
4020	PROV CONTRACT UNIT RESTRICTION ON PROCEDURE	452	TOTAL VISITS IN TOTAL NUMBER OF HOURS/DAY ANDTOTAL NUMBER OF HOURS/WEEK	-	-
4021	PROCEDURE NOT COVERED FOR BENEFIT PLAN	88	ENTITY NOT ELIGIBLE FOR BENEFIT FOR SUBMITTEDDATES OF SERVICE	QC	PATIENT
4022	ABORTION DIAGNOSIS INDICATED	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4023	GENDER IS NOT ALLOWED FOR COVERED NDC	585	DENIED CHARGE OR NON-COVERED CHARGE	QC	PATIENT
4024	MAXIMUM NUMBER OF REFILLS HAS BEEN REACHED	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	QH	PHYSICIAN
4025	NDC VS. AGE RESTRICTION	585	DENIED CHARGE OR NON-COVERED CHARGE	QC	PATIENT
4026	NDC VS. DAYS SUPPLY	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
4027	DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE	254	PRIMARY DIAGNOSIS CODE	-	-
4028	BENEFIT PLAN GENDER RESTRICTION ON DIAGNOSIS	86	DIAGNOSIS AND PATIENT GENDER MISMATCH	-	-
4029	BENEFIT PLAN POS RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4030	BENEFIT PLAN AGE RESTRICTION ON DIAGNOSIS	255	DIAGNOSIS CODE	-	-
4031	PROV CONTRACT GENDER RESTRICTION ON DIAGNOSIS	86	DIAGNOSIS AND PATIENT GENDER MISMATCH	-	-
4032	PROCEDURE CODE NOT ON FILE	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
4033	INVALID PROC MOD COMBINATION	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
4034	BENEFIT PLAN AGE RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4035	BENEFIT PLAN GENDER RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4036	PROV CONTRACT POS RESTRICTION ON PROCEDURE	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4037	PROCEDURE CODE VS. DIAGNOSIS RESTRICTION	488	DIAGNOSIS CODE(S) FOR THE SERVICES RENDERED	-	-
4038	SERVICE NOT COVERED FOR LIMITED BENEFIT PLAN	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4039	DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS	255	DIAGNOSIS CODE	-	-
4040	PRIMARY DIAGNOSIS CODE NOT ON FILE	254	PRIMARY DIAGNOSIS CODE	-	-
4041	SECONDARY DIAGNOSIS CODE NOT ON FILE	255	DIAGNOSIS CODE	-	-
4042	THIRD DIAGNOSIS CODE NOT ON FILE OR INACTIVE	255	DIAGNOSIS CODE	-	-
4043	FOURTH DIAGNOSIS CODE NOT ON FILE OR INACTIVE	255	DIAGNOSIS CODE	-	-
4044	REIMBURSEMENT RULE AGE RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4045	REIMBURSEMENT RULE/BENEFIT PLAN RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4046	NO REIMBURSEMENT RULE FOR RATE ID	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4047	FIFTH DIAGNOSIS CODE NOT ON FILE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4048	SIXTH DIAGNOSIS CODE NOT ON FILE	255	DIAGNOSIS CODE	-	-
4049	SEVENTH DIAGNOSIS CODE NOT ON FILE	255	DIAGNOSIS CODE	-	-
4050	EIGHTH DIAGNOSIS CODE NOT ON FILE	255	DIAGNOSIS CODE	-	-
4051	NINTH DIAGNOSIS CODE NOT ON FILE	255	DIAGNOSIS CODE	-	-
4052	TENTH DIAGNOSIS CODE NOT ON FILE	255	DIAGNOSIS CODE	-	-
4053	PRINCIPAL PROCEDURE CODE NOT ON FILE	666	SURGICAL PROCEDURE CODE	-	-
4054	FIRST OTHER PROCEDURE CODE NOT ON FILE	666	SURGICAL PROCEDURE CODE	-	-
4055	SECOND OTHER PROCEDURE CODE NOT ON FILE	666	SURGICAL PROCEDURE CODE	-	-
4056	THIRD OTHER PROCEDURE CODE NOT ON FILE	666	SURGICAL PROCEDURE CODE	-	-
4057	FOURTH OTHER PROCEDURE CODE NOT ON FILE	666	SURGICAL PROCEDURE CODE	-	-
4058	FIFTH OTHER PROCEDURE CODE NOT ON FILE	666	SURGICAL PROCEDURE CODE	-	-
4059	REVENUE CODE NOT ON FILE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4060	ELEVENTH DIAGNOSIS CODE NOT ON FILE	255	DIAGNOSIS CODE	-	-
4061	REIMBURSEMENT RULE CLAIM TYPE RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4062	REIMBURSEMENT RULE COND CODE RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4063	ICD-9-CM PROCEDURE CODE/AGE RESTRICTION	475	PROCEDURE CODE NOT VALID FOR PATIENT AGE	QC	PATIENT
4064	BENEFIT PLAN GENDER RESTRICTION ON ICD9 PROC	474	PROCEDURE CODE AND PATIENT GENDER MISMATCH	-	-
4065	ICD9-CM PROCEDURE REQUIRES ATTACHMENT	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4066	ICD9-CM PROCEDURE/DIAGNOSIS RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4067	NON-COVERED ICD-9-CM PROCEDURE CODE	666	SURGICAL PROCEDURE CODE	-	-
4068	REIMBURSEMENT RULE/PROV CONTRACT RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4069	REIMBURSEMENT RULE RESTRICTION ON DIAGNOSIS ROLE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4070	REIMBURSEMENT RULE MODIFIER RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4071	REIMBURSEMENT RULE PAYER RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4072	REIMBURSEMENT RULE TAXONOMY RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4076	TWELFTH DIAGNOSIS CODE NOT ON FILE	255	DIAGNOSIS CODE	-	-
4077	NON-COVERED REVENUE CODE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4085	INPATIENT PSYCH HOSP FOR MEMBERS AGE 22-64	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4095	REIMBURSEMENT RULE UNIT RESTRICTION	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
4096	MODIFIER 99 NOT ALLOWED	297	MEDICAL NOTES/REPORTS	-	-
4097	INVALID PROCESSING MODIFIER/RATE NOT FOUND	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4098	FUND CODE FOR AID CAT/LOC NOT FOUND	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4099	DRG NOT ON FILE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4113	UNIT DOSE PACKAGING COVERED FOR LTC RESIDENTS ONLY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4115	NO RBRVS CONVERSION FACTOR	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4117	ICD9 PROCEDURE IS NOT VALID FOR DATES OF SERVICE	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4120	PROCEDURE CODE REQUIRES QUADRANT	242	TOOTH NUMBERS, SURFACES, QUADRANTS INVOLVED	-	-
4128	ICD9 PROCEDURE 7-24 NOT ON FILE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4132	DRG GROUPER UNABLE TO ASSIGN DRG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4135	APC GROUPER UNABLE TO GROUP/PRICE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4136	BENEFIT PLAN BILL PR TYP RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4137	BENEFIT PLAN PERF PR TYP RESTRICTION ON ICD9 PROC	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4138	BILL PROV TYPE SPEC NOT VALID FOR COVERED-NDC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4139	PERF PROV TYPE SPEC NOT VALID FOR COVERED-NDC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4140	BENEFIT PLAN BILL PR TYP RESTRICTION ON PROCEDURE	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
4141	BENEFIT PLAN PERF PR TYP RESTRICTION ON PROCEDURE	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
4142	BENEFIT PLAN BILL PR TYP RESTRICTION ON REVENUE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4143	BENEFIT PLAN PERF PR TYP RESTRICTION ON REVENUE	488	DIAGNOSIS CODE(S) FOR THE SERVICES RENDERED	-	-
4144	PROV CONTRACT PERF PR TYP RESTRICTION ON DIAGNOSIS	488	DIAGNOSIS CODE(S) FOR THE SERVICES RENDERED	-	-
4145	PROV CONTRACT BILL PR TYP RESTRICTION ON DRG	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4146	PROV CONTRACT PERF PR TYP RESTRICTION ON DRG	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4147	PROV CONTRACT PERF PR TYP RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4148	PERF PROV TYPE SPEC NOT VALID FOR CONTRACT-NDC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4149	PROV CONTRACT BILL PR TYP RESTRICTION ON PROCEDURE	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
4150	PROV CONTRACT PERF PR TYP RESTRICTION ON PROCEDURE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4151	PROV CONTRACT BILL PR TYP RESTRICTION ON REVENUE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4152	PROV CONTRACT PERF PR TYP RESTRICTION ON REVENUE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4153	PRIMARY NDC ON MEDICAL REVIEW FOR PROV. CONTRACT	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4155	REIMBURSEMENT RULE POS RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4156	REIMBURSEMENT RULE PROV LOCAT RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4157	PROV CONTRACT/PROV CONTRACT RESTRICT ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4158	PROV CONTRACT/PROV CONTRACT RESTRICT ON DRG	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4159	PROV CONTRACT/PROV CONTRACT RESTRICT ON ICD9 PROC	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4160	PROVIDER CONTRACT RESTRICTION FOR CONTRACT NDC	218	NDC NUMBER	-	-
4161	PROV CONTRACT/PROV CONTRACT RESTRICT ON PROCEDURE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4162	PROV CONTRACT/PROV CONTRACT RESTRICT ON REVENUE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4164	INACTIVE DRUG	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4165	MAX DAY RESTRICTION FOR COVERED NDC	218	NDC NUMBER	85	BILLING PROVIDER
4166	REIMBURSEMENT RULE MEMB LOCAT RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4167	PROV CONTRACT UNIT RESTRICTION ON REVENUE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4168	BENEFIT PLAN UNIT RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4170	UNITS BILLED GREATER THAN ALLOWED	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4171	UNITS BILLED LESS THAN ALLOWED	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4177	PROV CONTRACT BILL PR TYP RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4180	SECOND DIAG CODE NOT COVERED FOR DATE OF SERVICE	255	DIAGNOSIS CODE	-	-
4181	THIRD DIAG CODE NOT COVERED FOR DATE OF SERVICE	255	DIAGNOSIS CODE	-	-
4182	FOURTH DIAG CODE NOT COVERED FOR DATE OF SERVICE	255	DIAGNOSIS CODE	-	-
4183	FIFTH DIAG CODE NOT COVERED FOR DATE OF SERVICE	255	DIAGNOSIS CODE	-	-
4184	SIXTH DIAG CODE NOT COVERED FOR DATE OF SERVICE	255	DIAGNOSIS CODE	-	-
4185	7 - 24 DIAG CODE NOT COVERED FOR DATE OF SERVICE	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4186	ADMIT DIAG CODE NOT COVERED FOR DATE OF SERVICE	232	ADMITTING DIAGNOSIS	-	-
4187	EMERG DIAG CODE NOT COVERED FOR DATE OF SERVICE	488	DIAGNOSIS CODE(S) FOR THE SERVICES RENDERED	-	-
4188	DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE(DTL)	254	PRIMARY DIAGNOSIS CODE	-	-
4189	SECOND DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)	255	DIAGNOSIS CODE	-	-
4190	THIRD DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)	255	DIAGNOSIS CODE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4191	FOURTH DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)	255	DIAGNOSIS CODE	-	-
4192	FIFTH DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)	255	DIAGNOSIS CODE	-	-
4193	SIXTH DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)	255	DIAGNOSIS CODE	-	-
4194	7 - 24 DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)	255	DIAGNOSIS CODE	-	-
4200	CLAIM PRICED AT ZERO	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4203	MODIFIER IS NOT COVERED	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
4207	CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE	142	ENTITY'S LICENSE/CERTIFICATION NUMBER	1X	LABORATORY
4208	INVALID CLIA CERTIFICATION/PROCEDURE CODE COMBINAT	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4209	NO PRICING SEGMENT FOR PROCEDURE/MODIFIER COMBINAT	499	NO RATE ON FILE WITH THE PAYER FOR THIS SERVICE FOR THIS ENTITY	1P	PROVIDER
4210	MILEAGE RATE NOT ON FILE FOR DATE OF SERVICE	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4211	TOOTH NUMBER/PROCEDURE CODE COMBINATION INVALID	244	TOOTH NUMBER OR LETTER	-	-
4212	INVALID CLIA LAB CODE/PROC CODE/MODIFIER COMBINAT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4214	SERVICE DATE PRIOR TO CLIA CERTIFICATION DATE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4215	CLIA NUMBER TERMINATED	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4222	NDC REQUIRES REVIEW	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4223	BENEFIT PLAN REVIEW RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4224	BENEFIT PLAN UNIT RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4227	REVENUE NOT COVERED FOR BENEFIT PLAN	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4229	BENEFIT PLAN REVIEW RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4231	MAX UNIT RESTRICTION FOR BILLED NDC	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4232	MAX DAY RESTRICTION FOR BILLED NDC	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	85	BILLING PROVIDER
4233	DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION	297	MEDICAL NOTES/REPORTS	-	-
4235	IMPROPER MODIFIER FOR PROCEDURE BILLED	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
4236	INVALID USE OF E DIAGNOSIS CODE	254	PRIMARY DIAGNOSIS CODE	-	-
4237	INVALID TYPE OF LEAVE FOR LTC CLAIM	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4240	PROCEDURE MUST BE BILLED SEPARATELY FOR EACH DOS	188	STATEMENT FROM-THROUGH DATES	-	-
4244	DIAGNOSIS NOT COVERED FOR BENEFIT PLAN	255	DIAGNOSIS CODE	-	-
4245	FOURTH MODIFIER NOT COVERED	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
4246	ADJUSTMENT PAID AMOUNT EXCEEDS THE CASH RECEIPT BA	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4248	MISSING MODIFIER FOR THIS PROCEDURE	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
4250	REIMBURSEMENT RULE PROV TYP RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4252	DX CODE 6-24 NOT ON FILE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4253	BENEFIT PLAN REVIEW RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4254	BENEFIT PLAN AGE RESTRICTION ON REVENUE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4256	BENEFIT PLAN MODIFIER RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4257	PROV CONTRACT MODIFIER RESTRICTION ON PROCEDURE	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4258	SECONDARY DIAG RESTRICTION FOR BILLED NDC	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4260	MEMBER NOT CODED FOR LTC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4261	MEMBER NOT CODED FOR CASEMIX	91	ENTITY NOT ELIGIBLE/NOT APPROVED DATES OF SRV	QC	PATIENT
4310	PROV CONTRACT ADMIT DIAG RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4311	PROV CONTRACT EMERG DIAG RESTRICTION ON PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4312	PROV CONTRACT PRIM DTL DIAG RESTRICT ON PROCEDURE	255	DIAGNOSIS CODE	-	-
4313	PROV CONTRACT PRIM/SEC DTL DIAG RESTRICT ON PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4314	BENEFIT PLAN CLAIM TYPE RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4315	PROV CONTRACT HDR DIAG RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4316	PROV CONTRACT DTL DIAG RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4317	PROV CONTRACT ADMIT DIAG RESTRICTION ON ICD9	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4318	PROV CONTRACT DTL DIAG RESTRICTION ON ICD9	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4319	PROV CONTRACT HDR DIAG RESTRICTION ON ICD9	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4320	PROV CONTRACT ADMIT DIAG RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4321	PROV CONTRACT DTL DIAG RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4322	PROV CONTRACT PRIM/SEC DTL DIAG RESTRICT ON REV	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4362	PROV CONTRACT TOB RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4363	PROV CONTRACT TOB RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4364	PROV CONTRACT TOB RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4365	PROV CONTRACT TOB RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4371	BENEFIT PLAN CLAIM TYPE RESTRICTION ON PROCEDURE	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4373	NDC COVERED BENEFIT CLAIM TYPE RESTRICTION	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4374	BENEFIT PLAN CLAIM TYPE RESTRICTION ON REVENUE	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4376	BENEFIT PLAN CLAIM TYPE RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4711	PROV CONTRACT AGE RESTRICTION ON ADMIT DIAG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4712	PROV CONTRACT AGE RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4714	PROV CONTRACT AGE RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4715	PROV CONTRACT AGE RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4716	AGE RESTRICTION FOR BILLED ICD9	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4721	PROV CONTRACT PRIM/SEC DTL DIAG RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4723	BENEFIT PLAN DTL DIAGNOSIS RESTRICTION ON ICD9	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4724	BENEFIT PLAN PRIM/SEC DTL DIAG RESTRICTION ON ICD9	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4726	BENEFIT PLAN ADMIT DIAG RESTRICTION ON ICD9	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4730	REIMBURSEMENT RULE RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4731	BENEFIT PLAN DTL DIAG RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4732	BENEFIT PLAN ADMIT DIAG RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4733	PROV CONTRACT ADMIT DIAG RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4734	PROV CONTRACT DTL DIAGNOSIS RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4736	BENEFIT PLAN DTL DIAG RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4741	BENEFIT PLAN ADMIT DIAG RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4742	BENEFIT PLAN EMERG DIAG RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4743	BENEFIT PLAN PRIM/SEC DTL DIAG RESTRICT ON PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4744	BENEFIT PLAN PRIM/SEC DTL DIAG RESTRICTION ON REV	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4745	BENEFIT PLAN HDR DIAG RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4746	BENEFIT PLAN PRIM DTL DIAG RESTRICT ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4751	PROV CONTRACT TOB RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4760	PROV CONTRACT REVIEW RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4762	PROV CONTRACT POS RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4765	ICD9 PROC NOT COVERED FOR BENEFIT PLAN	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4766	BENEFIT PLAN AGE RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4767	BENEFIT PLAN POS RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4768	BENEFIT PLAN REVIEW RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4776	PROV CONTRACT BILL PR TYP RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4801	PROCEDURE NOT COVERED BY PROVIDER CONTRACT	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4802	DIAGNOSIS NOT COVERED BY PROVIDER CONTRACT	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4804	REVENUE NOT COVERED BY PROVIDER CONTRACT	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4805	DRG NOT COVERED BY PROVIDER CONTRACT	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4806	ICD9 PROC NOT COVERED BY PROVIDER CONTRACT	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4812	PROV CONTRACT REVIEW RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4813	PROV CONTRACT REVIEW RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4814	PROV CONTRACT REVIEW RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4821	BENEFIT PLAN POS RESTRICTION ON PROCEDURE	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4822	PROV CONTRACT POS RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4825	MIXED HOLIDAY/WEEKEND/WEEKDAY DATES	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4831	NO REIMBURSEMENT RULE FOR SERVICE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4845	PROV CONTRACT REVIEW RESTRICTION ON DRG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4863	NDC COVERED FOR A PORTION OF THE DOS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4866	BENEFIT PLAN POS RESTRICTION ON REVENUE	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4867	PROV CONTRACT POS RESTRICTION ON REVENUE	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4871	PROV CONTRACT CLAIM TYPE RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4872	PROV CONTRACT CLAIM TYPE RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4874	PROV CONTRACT CLAIM TYPE RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4875	PROV CONTRACT CLAIM TYPE RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4876	PROV CONTRACT CLAIM TYPE RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4881	PROV CONTRACT POS RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4882	DRG NOT COVERED FOR BENEFIT PLAN	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4883	BENEFIT PLAN REVIEW RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4884	BENEFIT PLAN AGE RESTRICTION ON DRG	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
4886	BENEFIT PLAN CLAIM TYPE RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4887	BENEFIT PLAN POS RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4890	PROV CONTRACT AGE RESTRICTION ON PRIMARY DIAG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4891	PROV CONTRACT AGE RESTRICTION ON SECONDARY DIAG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4892	PROV CONTRACT AGE RESTRICTION ON THIRD DIAG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4893	PROV CONTRACT AGE RESTRICTION ON FOURTH DIAG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4894	PROV CONTRACT AGE RESTRICTION ON FIFTH DIAG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4895	PROV CONTRACT AGE RESTRICTION ON SIXTH DIAG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4896	PROV CONTRACT AGE RESTRICTION ON SEVENTH DIAG	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4900	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4901	BENEFIT PLAN COND CODE RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4902	BENEFIT PLAN OCCUR CODE RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4903	BENEFIT PLAN RESTRICTION ON DIAGNOSIS ROLE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4910	PROV CONTRACT/BENEFIT PLAN RESTRICT ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4911	PROV CONTRACT COND CODE RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4912	PROV CONTRACT OCCUR CODE RESTRICTION ON DIAGNOSIS	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4913	PROV CONTRACT RESTRICTION ON DIAGNOSIS ROLE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4914	PROV CONTRACT OCCUR CODE RESTRICTION ON DRG	719	NUBC OCCURRENCE CODE(S)	-	-
4920	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4921	BENEFIT PLAN COND CODE RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4922	BENEFIT PLAN OCCUR CODE RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4930	BENEFIT PLAN RESTRICTION FOR CONTRACT DRG	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4931	PROV CONTRACT COND CODE RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4935	BENEFIT PLAN GENDER RESTRICTION ON DRG	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
4936	PROV CONTRACT GENDER RESTRICTION ON DRG	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
4940	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4941	BENEFIT PLAN COND CODE RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4942	BENEFIT PLAN OCCUR CODE RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4944	PROV CONTRACT GENDER RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4950	PROV CONTRACT/BENEFIT PLAN RESTRICT ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4951	PROV CONTRACT COND CODE RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4952	PROV CONTRACT OCCUR CODE RESTRICTION ON ICD9 PROC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4963	PROV CONTRACT GENDER RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4964	PROV CONTRACT GENDER RESTRICTION ON REVENUE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4967	BENEFIT PLAN GENDER RESTRICTION ON REVENUE	455	REVENUE CODE FOR SERVICES RENDERED	-	-
4970	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4971	BENEFIT PLAN COND CODE RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4972	BENEFIT PLAN OCCUR CODE RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4975	PROV CONTRACT/BENEFIT PLAN RESTRICT ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4976	PROV CONTRACT COND CODE RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4977	PROV CONTRACT OCCUR CODE RESTRICTION ON REVENUE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4980	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4981	BENEFIT PLAN COND CODE RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4982	BENEFIT PLAN OCCUR CODE RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4990	PROV CONTRACT/BENEFIT PLAN RESTRICT ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4991	PROV CONTRACT COND CODE RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
4992	PROV CONTRACT OCCUR CODE RESTRICTION ON PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
4999	THIS DRUG NOT COVERED BY MEDICARE PART D	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	85	BILLING PROVIDER
5000	EXACT DUPLICATE - INPATIENT CLAIM	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5001	SUSPECT DUPLICATE - INPATIENT CLAIM- DIFFERENT PROVIDER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5002	CONFLICT - INPATIENT VS OUTPATIENT	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5003	CONFLICT - INPATIENT VS LONG TERM CARE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5004	EXACT DUPLICATE - INPATIENT/LTC CROSSOVER A	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5005	SUSPECT DUPLICATE - INPATIENT/LTC CROSSOVER A	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5006	EXACT DUPLICATE - PHYSICIAN CROSSOVER	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5007	SUSPECT DUPLICATE - PHYSICIAN CROSSOVER- DIFFERENT PROVIDER	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5008	CONFLICT- PHYSICIAN VS CROSSOVER B	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5009	CONFLICT-LONG TERM CARE VS CROSSOVER A	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5010	EXACT DUPLICATE-OUTPATIENT CLAIM	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5011	SUSPECT DUPLICATE-OUTPATIENT CLAIM-DIFFERENT PROVIDER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5012	EXACT DUPLICATE - OUTPATIENT/HOME HEALTH/ CROSSOVER CLAIM	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5013	SUSPECT DUPLICATE - OUTPATIENT/HOME HEALTH/ CROSSOVER CLAIM	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5014	EXACT DUPLICATE-OUTPATIENT LAB SERVICES	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5015	SUSPECT DUPLICATE OUTPATIENT LAB SERVICES DIFFERENT PROVIDER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5016	EXACT DUPLICATE OUTPATIENT RADIOLOGICAL SERVICES	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5017	SUSPECT DUPLICATE-OUTPATIENT RADIOLOGY SERVICES	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5018	SUSPECT DUPLICATE OUTPATIENT SURGICAL SERVICES (OPERATION ROOM / AMB SURG CTR)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5019	SUSPECT DUPLICATE OUTPATIENT SERGICAL SERVICES (OPER ROOM/AMB SWG CTR)-DIFFEREN	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5020	SUSPECT DUPLICATE OUTPATIENT PROCEDURE	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5021	SUSPECT DUPLICATE OUTPATIENT PROCEDURE(OPER ROOM/AMB SURG CTR) DIFFERENT PROVID	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5022	SUSPECT DUPLICATE OUTPATIENT PROCEDURES (OPER ROOM/ AMB SURG CTR)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5023	SUSPECT DUPLICATE OUTPATIENT PROCEDURE (OPER ROOM/ AMB SURG CTR) DIFFERENT PROV	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5024	SUSPECT DUPLICATE OUTPATIENT SERGICAL SERVICES	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
5025	SUSPECT DUPLICATE OUTPATIENT SERGICAL SERVICES (EMERG ROOM/ CLINIC) DIFFERENT P	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5026	SUSPECT DUPLICATE OUTPATIENT SERGICAL SERVICES EMERGENCY ROOM/ CLINIC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5027	SUSPECT DUPLICATE OUTPATIENT SURGICAL SERVICES- EMERG ROOM/CLINIC- DIFFERENT PR	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5028	OPD EXACT DUP CRITERIA=E- CLAIM TYPE O-UB04 INV 03	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5029	OPD SUSPECT DUP CRITERIA=E-CLAIM TYPE O -UB4 INV 3	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5030	XACT DUPLICATE OUTPATIENT PROCEDURES (OPER ROOM/AMB SURG CTR/EMERG ROOM/CLINIC)	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5031	SUSPECT DUPLICATE OUTPATIENT PROCEDURE (OR/AMB SURG CTR/ER/CLINIC) -DIFFERENT P	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5032	EXACT DUPLICATE-OUTPATIENT PROCEDURES (OPER ROOM / EMERG ROOM/ CLINIC)	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5033	SUSPECT DUPLICATE OUTPATIENT PROCEDURES- DIFFERENT PROVIDER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5034	OPD EXACT DUP CRITERIA=E1-CLAIM TYPE O-UB04 INV 03	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5035	OPD SUSPECT DUP CRITERIA=E1-CLAIM TYP O -UB4 INV 3	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5036	OPD EXACT DUP CRITERIA=F- CLAIM TYPE O-UB04 INV 03	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5037	OPD SUSPECT DUP CRITERIA=F- CLAIM TYP O -UB4 INV 3	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5038	OPD EXACT DUP CRITERIA=F1-CLAIM TYPE O-UB04 INV 03	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5039	OPD SUSPECT DUP CRITERIA=F1-CLAIM TYP O -UB4 INV 3	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5040	OPD EXACT DUP CRITERIA=G-CLAIM TYPE O-UB04 INV 03	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5041	OPD SUSPECT DUP CRITERIA=G -CLAIM TYP O -UB4 INV 3	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5042	OPD EXACT DUP CRITERIA=H-CLAIM TYPE O-UB04 INV 03	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5043	OPD SUSPECT DUP CRITERIA=H -CLAIM TYP O -UB4 INV 3	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5044	EXACT DUPLICATE - PHYSICAN CLAIM	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5045	SUSPECT DUPLICATE-PHYSICIAN CLAIM- DIFFERENT PROVIDER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5046	EXACT DUPLICATE OUTPATIENT PROCEDURES (CLINIC)	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5047	SUSPECT DUPLICATE OUTPATIENT PROCEDURES (CLINIC)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5048	SUSPECT DUPLICATE OUTPATIENT PROCEDURES (CLINIC)	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5049	SUSPECT DUPLICATE OUTPATIENT PROCEDURE (CLINIC)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5050	EXACT DUPLICATE HOME HEALTH CLAIM	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5051	SUSPECT DUPLICATE- HOME HEALTH -DIFFERENT PROVIDER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5052	EXACT DUPLICATE - LONG TERM CARE	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5053	SUSPECT DUPLICATE-LONG TERM CARE-DIFFERENT PROVIDER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
5054	OPD EXACT DUP CRITERIA=M-CLAIM TYPE O-UB04 INV 03	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5055	OPD SUSPECT DUP CRITERIA=M-CLAIM TYP O -UB4 INV 3	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5056	DUPLICATE SERVICE (DENTAL ONLY)	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5057	DUPLICATE SERVICE (PHARMACY ONLY)	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	85	BILLING PROVIDER
5058	OPD EXACT DUP CRITERIA=M1-CLAIM TYPE O-UB04 INV 03	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5059	OPD SUSPECT DUP CRITERIA=M1-CLAIM TYP O -UB4 INV 3	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5060	OPD EXACT DUP CRITERIA=N-CLAIM TYPE O-UB04 INV 03	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5061	OPD SUSPECT DUP CRITERIA=N-CLAIM TYP O -UB04 INV 3	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5062	EXACT DUPLICATE OUTPATIENT PROCEDURES (TREATMENT ROOM)	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
5063	SUSPECT DUPLICATE OUTPATIENT PROCEDURES (TREATMENT ROOM)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5064	CONFLICT: INPATIENT VS. CROSSOVER A	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5065	CONFLICT: HOME HEALTH VS. OUTPATIENT	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5066	CONFLICT: HOME VS. PHYSICIAN	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5067	CONFLICT: HOME VS. CROSSOVER B	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5068	CONFLICT: HOME HEALTH VS. CROSSOVER A	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5069	CONFLICT: HOME HEALTH VS. CROSSOVER C	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5070	CONFLICT: OUTPATIENT VS. CROSSOVER C	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5071	PA IS REQUIRED FOR BASIC MEMBERS	84	SERVICE NOT AUTHORIZED	-	-
5072	CONFLICT: LTC VS. PROV TYPE 58 59 62 63 64 66 68	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5073	CONFLICT: HOSPICE VS. LONG TERM CARE	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5074	EXACT DUPLICATE - DIFFERENT PHYSICIAN CLAIM	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5075	EXACT DUPLICATE - DIFFERENT HOME HEALTH CLAIM	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5076	EXACT DUPLICATE - DIFFERENT CROSSOVER B CLAIM	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5077	LTC MLOA CLAIM SUSP W INP / PART A	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5078	S5160 & S5161 CAN NOT BE BILLED WITH LTC SAME DOS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5079	CONFLICT: LTC VS PHYSICIAN(S5160 & S5161) SAME DOS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5080	SURG/ASSIST SURG SAME DOS SAME PROVIDER	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5081	CONFLICT: ASC FACILITY VS OPD FACILITY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5082	ONE PRIMARY SURGERY PER DAY	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5083	LIMIT 1 SURGICAL CODE WITH DIFFERENT MOD PER DAY	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5084	ASST SURGERY BILATERAL LIMIT MOD 80	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5085	ONE PRIMARY ASSIST SURGERY PER DAY	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
5086	ASST SURGERY BILATERAL LIMIT MOD 82	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5087	ASST SURGERY BILATERAL LIMIT MOD 81	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5088	CONFLICT: ASC FACILITY VS. OPD FACILITY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5089	CONFLICT: ASC FACILITY VS. HLHC HOSPITAL	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5090	CONFLICT: ASC FACILITY VS. HLHC FACILITY	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5091	DIFFERENT PROVIDER FROM SAME GROUP NOT ALLOWED	585	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5092	CONFLICT:HOME HEALTH VS. INPATIENT	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5093	CONFLICT:HOME HEALTH VS. LTC	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
5094	MODIFIER 'SG' REQUIRED FOR ALL PROCEDURE CODES	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5096	NCCI CONFLICT WITH ADJUSTED OTH SERV PREV PAID	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5200	PAPE SERVICES SHOULD BE ON SINGLE CLAIM	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5210	ATP SERVICES SHOULD BE ON SINGLE CLAIM	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
5927	NCCI - ANOTHER SERVICE PREV PAID – SAME CLAIM	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5928	NCCI – ANOTHER SERVICE PREV PAID – OTHER CLAIM	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5929	NCCI – CONFLICT WITH OTHER SERVICE PREV PAID	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
5930	MUE UNITS EXCEEDED	585	DENIED CHARGE OR NON-COVERED CHARGE		
5935	LABORATORY PANELS DENIED	12	ONE OR MORE ORIGINALLY SUBMITTED PROCEDURE CODES HAVE BEEN COMBINED	-	-
6000	MANUAL PRICING REQUIRED	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6001	MANUAL PRICING NOT ALLOWED ON ADJUSTMENT	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
6002	INVALID UNIT CODE FOR ANESTHESIA	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
6003	PAID AMOUNT IS LESS THAN MINIMUM THRESHOLD - HDR	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6004	PAID AMOUNT EXCEEDS THRESHOLD - HDR	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6005	COPAY REVIEW AMOUNT WAS REACHED	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6007	PAID AMOUNT LESS THAN MINIMUM THRESHOLD - DTL	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
6008	AMOUNT EXCEEDS MAXIMUM THRESHOLD - DTL	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6018	EXCESSIVE MLOA DAYS TAKEN	498	MAXIMUM LEAVE DAYS EXHAUSTED	-	-
6019	EXCESSIVE MLOA DAYS TAKEN	498	MAXIMUM LEAVE DAYS EXHAUSTED	-	-
6021	ATP ELIGIBLE CODE	20	ACCEPTED FOR PROCESSING	-	-
6022	ATP BUNDLED CLAIM	20	ACCEPTED FOR PROCESSING	-	-
6020	MLOA DAYS EXCEEDS MAX	263	LENGTH OF TIME FOR SERVICES RENDERED	-	-
6023	ATP PROCEDURE NOT ON MAX FEE TABLE (PROFESSIONAL)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6024	ATP PROCEDURE NOT ON MAX FEE TABLE (OUTPATIENT)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
6025	ATP PROCEDURE NOT ON ATP CODE TABLE (PROFESSIONAL)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6026	ATP PROCEDURE NOT ON ATP CODE TABLE (OUTPATIENT)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6027	NO TPL PRICING METHOD FOUND FOR ATP PRICING FOR PROFESSIONAL CLAIM	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6028	NO TPL PRICING METHOD FOUND FOR ATP PRICING FOR OUTPATIENT CLAIM	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6030	PROVIDER PRICING METHOD NOT FOUND (OUTPATIENT)	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6031	PAPE ELIGIBLE PROCEDURE	20	ACCEPTED FOR PROCESSING	-	-
6032	SYSTEM GENERATED CLAIM PAYING PAPE PRICE	20	ACCEPTED FOR PROCESSING	-	-
6040	NMLOA AUDIT	498	MAXIMUM LEAVE DAYS EXHAUSTED	-	-
6041	NMLOA AUDIT	498	MAXIMUM LEAVE DAYS EXHAUSTED	-	-
6125	RETURN MONEY VOID / MATCHED CLM ADJUSTED OR VOIDED	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6126	MODIFIER MANUALLY PRICED	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
6140	CLAIM WAS MANUALLY PRICED	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
6760	CLAIM SUSPENDED FOR ATTACHMENT REVIEW	297	MEDICAL NOTES/REPORTS	-	-
6761	DCN IS INVALID AND ATTACHMENT REQUIRED FOR SERVICE	297	MEDICAL NOTES/REPORTS	-	-
6762	ATTACHMENT MISSING FOR PODIATRIC SERVICES	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8000	1 CASE CONSULT IN 3 MONTHS = 2 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8001	LIMIT 1 PROC CODE PER MEMBER PER DAY-VARIOUS CODES	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8002	ESRD RELATED SERVICES 1 PER MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8003	PA IS REQUIRED FOR BASIC MEMBERS	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
8004	MODIFIER 26 REQUIRED IN HOSPITAL SETTING	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
8005	CONTRACEPTIVE INJECTABLE 3MTH. DEPRO-PROVERA	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
8006	CONTRACEPTIVE INJECTABLE LUNELLE 1 PER MONTH	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
8007	T1028, 1 ASSESSMENT = 3 COMPONENTS/UNITS PER YEAR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8008	T1024, 3 TEAM MEETINGS = 9 UNITS/COMPONENTS PER YR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8009	1 ASSIST AT SURGERY/PER MEMB/PER DAY	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
8010	LIMIT 1 ANESTHESIA CODE PER MEMBER PER DAY	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8011	2 MONURAL CODE V5241 DISPENSING FEES IN 5 YEARS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8012	8 VISITS 99402 ALLOWED FOR CHC/FP PER YEAR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8013	2 REEVALUATIONS (99456-TS) PER YEAR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8014	PHARMACY CODES - MAX 31 UNITS PER MONTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8015	ORTHOTICS - 1 UNIT IN 1 YEAR FROM DOS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8016	ORTHOTICS 2 UNITS IN 1 YEAR FROM DOS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8017	ORTHOTICS 4 UNITS IN 1 YEAR FROM DOS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8018	ORTHOTICS 3 UNITS IN 6 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8019	ORTHOTICS 6 UNITS IN 1 YEAR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8020	ORTHOTICS 8 UNITS IN 1 YEAR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8021	ORTHOTIC 1 UNIT IN 3 YEARS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8022	PROSTHETICS 12 UNITS IN 1 YEAR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8023	2 STOCKINGS IN 7 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8024	1 LITHIUM ION BATTERY CHARGER IN 2 YEARS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8025	HOME HEALTH PT LIM 20 VIS (120 UNITS) 12 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8026	HOME HEALTH OT LIM 20 VIS (120 UNITS) 12 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8027	HOME HEALTH ST LIM 35 VIS (140 UNITS)12 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8028	DME 1 UNIT IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8029	DME 2 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8030	DME 3 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8031	DME 4 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8032	DME 10 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8033	DME LIMIT 6 UNITS IN 1 MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8034	DME 12 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8035	DME 18 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8036	DME LIMIT 20 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8037	DME LIMIT 30 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8038	DME LIMIT 31 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8039	DME LIMIT 35 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8040	DME LIMIT 40 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8041	DME LIMIT 60 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8042	DME LIMIT 93 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8043	DME LIMIT 100 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8044	DME LIMIT 120 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8045	DME LIMIT 250 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8046	DME LIMIT 720 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8047	DME LIMIT 1000 UNITS IN 1 CALENDAR MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8048	DME LIMIT 1 UNIT IN 3 CALENDAR MONTHS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8049	DME LIMIT 2 UNIT IN 3 CALENDAR MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8050	DME LIMIT 3 UNITS IN 3 MONTHS MOD=KS ONLY	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8051	DME LIMIT 4 UNITS IN 3 CALENDAR MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8052	DME LIMIT 5 UNITS IN 3 MTHS MODIFR KS ONLY	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8053	DME LIMIT 6 UNITS IN 3 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8054	DME LIMIT 15 UNITS IN 3 MTHS MOD KX ONLY	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8055	DME LIMIT 8 UNITS IN 3 MTHS MOD KX ONLY	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8056	DME LIMIT 9 UNITS IN 3 CALENDAR MTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8057	DME LIMIT 10 UNITS IN 6 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8058	DME LIMIT 1 UNIT IN 6 MONTHS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8059	DME LIMIT 2 UNITS IN 6 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8060	DME LIMIT 16 UNITS IN 6 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8061	DME LIMIT 1 UNIT IN 12 MONTHS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8062	DME LIMIT 2 UNITS IN 12 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8063	DME LIMIT 4 UNITS IN 12 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8064	DME LIMIT 8 UNITS IN 12 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8065	DME LIMIT 12 UNITS IN 12 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8066	DME LIMIT 1 UNIT IN 24 MONTHS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8067	DME LIMIT 1 UNIT IN 3 YEARS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8068	DME LIMIT 2 UNITS IN 3 YEARS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8069	DME LIMIT 1 UNIT IN 5 YEARS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8070	LIMIT 27 UNITS PER MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8071	DME LIMIT 36 UNITS PER MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8072	DME LIMIT 12 PER MNTH PER WOUND=108 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8073	DME LIMIT 30 PER MTH PER WOUND=27O UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8074	DME LIMIT 31 PER MTH PER WOUND=279 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8075	DME LIMIT 45 PER MTH PER WOUND=405 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8076	DME LIMIT 60 PER MTH PER WOUND=540 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8077	DME LIMIT 80 PER MTH PER WOUND=720 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8078	DME LIMIT 100 PER MTH PER WOUND=900 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8079	DME LIMIT 160 PER MTH PER WOUND=1440 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8080	DME LIMIT 200 PER MTH PER WOUND=1800 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8081	DME LIMIT 240 PER MTH PER WOUND=2160 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8082	DME LIMIT 100 PER WOUND IN 3 MTHS =900 UNITS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8083	DME LIMIT 11 UNITS PER MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8084	DME LIMIT 150 UNITS PER MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8085	DME LIMIT 124 UNITS PER MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8086	DME LIMIT 15 UNITS PER MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8087	DME LIMIT 90 UNITS PER MONTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8088	SCREENING/INTAKE 8 UNITS T1023 PER MBR PER 12 MTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8089	DAY HABILITATION LIMIT 1 PER DAY EXCEPT MOD-22	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8090	PA REQUIRED FOR MOBILITY REPAIR OVER $1,000	84	SERVICE NOT AUTHORIZED	-	-
8091	MODIFIER 26 OR TC REQUIRED FOR PROCEDURE CODES IN GROUP 4113	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
8092	ORTHOTIC AND PROSTHETIC LIMIT - 4 UNITS PER MEMBER PER YEAR FROM LAST DOS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8093	ORTHOTIC AND PROSTHETIC LIMIT - 6 UNITS PER MEMBER PER YEAR FROM LAST DOS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8094	ORTHOTIC AND PROSTHETIC LIMIT - 8 UNITS PER MEMBER PER YEAR FROM LAST DOS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8095	ORTHOTIC AND PROSTHETIC LIMIT - 12 UNITS PER MEMBER PER YEAR FROM LAST DOS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8096	ORTHOTIC LABOR AND REPAIR CODES REQUIRE PA IF OVER $1000.00 PER MONTH	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
8097	PROSTHETIC LABOR AND REPAIR CODES REQUIRE PA IF OVER $1000.00 PER MONTH	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
8098	MODIFIER REQUIRED FOR VARIOUS CAPPED RENTAL/PURCHASE CODES. MODIFIERS VALUES KH	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
8099	MODIFIER REQUIRED FOR VARIOUS OXYGEN CODES.MODIFIERS VALUES QF QG RR U2.	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
8100	TOOTH PREVIOUSLY EXTRACTED	215	DATE OF TOOTH EXTRACTION/EVOLUTION	-	-
8101	MODIFIER REQUIRED FOR CHRONIC THERAPY SERVICES	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8102	DME SURGICAL CODES REQUIRE ONE OF THE A1 THROUGH A9 MODIFIERS.	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
8103	HIT NURSING VISIT CODES 99601 AND 99602 REQUIRE MODIFIER SD.	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
8104	DIABETIC SUPPLIES/INFUSION SUPPLIES REQR MODIFIER	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
8105	PROFESSIONAL COMPONENT NOT ALLOWED FOR THIS SERVICE.	454	PROCEDURE CODE FOR SERVICES RENDERED	-	-
8106	ENTERAL PROCEDURE CODES REQUIRE A MODIFIER	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
8107	ORTHOTIC AND PROSTHETIC CODES REQUIRE LT/RT MODIFIER	453	PROCEDURE CODE MODIFIER(S) FOR SERV(S) RENDERED	-	-
8108	PA REQUIRED FOR MONAURAL HEARING AIDS IF COSTS EXCEEDS $550.00	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
8109	PA IS REQUIRED FOR BINAURAL, CROS AND BICROS HEARING AIDS IF COSTS EXCEEDS $1,1	252	AUTHORIZATION/CERTIFICATION NUMBER	-	-
8110	ORTHOTIC AND PROSTHETIC LIMIT - 1 UNIT PER MEMBER IN 1 YEAR FROM LAST DOS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8111	ORTHOTIC - PROSTHETIC - LIMIT 2 UNITS PER MEMBER PER YEAR FROM DOS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8112	LIMIT 10 UNITS PER DAY PROC 80100	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8113	LIMIT 13 UNITS PER DAY PROC 80101	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8114	LIMIT 1 UNIT PER DAY - VARIOUS CODES	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8115	TEMP AUDIT 8115	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8116	LIMIT 4 UNITS PER DAY PROC 80102	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8117	TEMP AUDIT 8117	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8118	LIMIT 1 CESAREAN PER DAY (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8119	TEMP AUDIT 8119	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8120	LIMIT 1 LAPAROSCOPIC CHOLECYSTECTOMY PER DAY(SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8121	TEMP AUDIT 8121	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8122	FIRST MONTHS RENTAL OF VARIOUS CAPPED RENTAL CODES LIMIT 1 IN 5 YEARS WITH MODI	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8123	SECOND AND THIRD MONTHS RENTAL OF VARIOUS CAPPED RENTAL CODES LIMIT 2 IN 5 YEAR	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8124	10 MONTHS CAPPED RENTAL ALLOWED IN 5 YEARS FOR VARIOUS CAPPED RENTAL CODES LIMIT	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8125	VARIOUS REPAIR/MOBILITY CODES REQUIRE A MOD. MOD VALUES NU RP RR UB UC UE U1	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
8126	MODIFIER REQUIRED FOR CODES A4450, A4452 AND A5120. MODIFIER VALUES AU AV AW	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8127	TRANSPORTATION T2003 LIMIT - 2 ONE WAY TRIPS / DAY	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8128	AFC CODE S5140 TF/U5 LIMIT 14 UNITS PER CAL YEAR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8129	PHARMACY PLACE OF SERVICE 01 NOT ALLOWED	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8130	T4536 T4538 T4539 NOT ALLOWED W DIAPER CODE BILLED	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8131	DME LIMIT 1 UNIT PER MONTH (RENTAL ONLY)	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8132	DME LIMIT 13 UNITS IN 3 YEARS (MOD RR ONLY)	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8133	DME CONFLICT: PURCHASE VS RENTAL IN 3 YEARS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8134	LIMIT 1 IN 3 YEARS ON 1ST MONTH OF CAPPED RENTAL	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8135	2ND & 3RD MONTHS CAPPED RENTAL- LIMIT 2 IN 3 YEARS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8136	LIMIT 10 IN 3 YEARS FOR 10 MONTHS OF CAPPED RENTAL	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8137	DME RENTAL NOT ALLOWED AFTER PURCHASE IN 3 YEARS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8138	DME LIMIT 13 UNITS IN 5 YEARS (MOD RR ONLY)	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8139	DME CONFLICT: PURCHASE VS RENTAL IN 5 YEARS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8140	DME RENTAL NOT ALLOWED AFTER PURCHASE IN 5 YEARS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8141	DME CONFLICT: PURCHASE VS RENTAL IN 1 YEAR	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8142	DME CONFLICT: PURCHASE VS RENTAL IN 24 MONTHS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8143	DME LIMIT 13 UNITS IN 24 MONTHS (MOD RR ONLY)	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8144	NDC CODE - UNITS - AND UNIT DESCRIPTOR REQUIRED	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8145	MAX UNITS 1 PER DAY FOR NON-SCHOOL BASED PROVIDERS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8146	MAX UNITS 3 PER DAY FOR NON-SCHOOL BASED PROVIDERS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8147	MAX UNITS 4 PER DAY FOR NON-SCHOOL BASED PROVIDERS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8148	MAX UNITS 6 PER DAY FOR NON-SCHOOL BASED PROVIDERS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8149	MAX UNITS 7 PER DAY FOR NON-SCHOOL BASED PROVIDERS	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
8150	NEW AND DELETED CODES CANNOT BE BILLED ON THE SAME DAY	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
8156	MODIFIER REQUIRED FOR CODE 96110-NOT PRESENT	453	PROCEDURE CODE MOIDIFIER(S) FOR SERVICE(S) RENDERED	-	-
8185	MASS ADJUSTMENT - RETROACTIVE RATE CHANGE.	631	REIMBURSEMENT RATE	-	-
8242	ATP/PAPE ADJUSTMENT/VOID EOB	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8250	INVALID COMBINATION OF PROCEDURES	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8251	SPEECH THERAPY LIMIT 35 VISITS IN 12 MONTHS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8252	INVALID COMBINATION OF PROCEDURES	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8253	VISIT & SURGERY NOT ALLOWED SAME DAY/SAME POS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8254	MULTIPLE VISITS NOT ALLOWED SAME DAY	612	PER DAY LIMIT AMOUNT	-	-
8255	CHIROPRACTOR MANIPULATION / VISIT = 1 PER DAY	612	PER DAY LIMIT AMOUNT	-	-
8256	CHIROPRACTOR MANIPULATION / VISIT 20 PER YEAR	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8257	CONFLICT ACUPUNCTURE WITH METHADONE ADMINIST	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8258	MONTHLY ESRD CONFLICTS WITH DAILY ESRD	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8259	MONTHLY ESRD 1 PER MONTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8260	1 LEVEL OF MUNICIPAL MEDICAID STUDENT/DAY	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8261	10 HOURS PDN PER DAY FOR 22 SCHOOL DAYS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8262	MUNI MEDICAID PROCS CONFLICT WITH THERAPY	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8263	LAB UNRINALYSIS CONFLICT W/ EACH OTHER ON SAME DAY	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8264	OTHER LAB TESTS CONF W/GENERAL HEALTH LAB TESTS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8265	OTHER LAB TESTS CONFLICT W/ OBSTETRIC PANEL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8266	LIPID PANEL CONFLICTS WITH OTHER LAB TESTS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8267	LAB HEMATOLOGY CONFLICT W/EACH OTHER ON SAME DOS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8268	PHYSICAL THERAPY CODES LIMIT 1 HR (4 UNITS) PER DY	612	PER DAY LIMIT AMOUNT	-	-
8269	OCCUPATIONAL THERAPY LIMIT 1 HR (4 UNITS) PER DAY	612	PER DAY LIMIT AMOUNT	-	-
8270	SPEECH THERAPY CODES LIMIT 1 HR (4 UNITS) PER DAY	612	PER DAY LIMIT AMOUNT	-	-
8271	ANTEPARTUM CARE LIMIT 1 OF EITHER CODE PER YEAR	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8272	AMBULANCE ALS CONFLICTS WITH BLS SAME DAY	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8273	2 PAIRS SHOES DURING 12 MONTH PERIOD	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8274	2 MONAURAL HEARING AIDS IN 5 YEARS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8275	1 BINAURAL HEARING AID IN 5 YEARS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8276	1 DISPENSING FEE IN 5 YRS (BILATERAL)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8277	EVAL & MANGMNT CONFLICTS W/TREATMENT PROC SAME DAY	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8278	DELIVERY CONFLICTS WITH FETAL STRESS TEST	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
8279	1 NEW PATIENT VISIT WITHIN 3 YEARS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8280	CONSULTATION CONFLICTS W/ REFRACTION	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8281	DIAPERS LIMIT 248 PER MEMB/PER CAL MONTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8282	4 STOCKINGS IN 6 MONTHS PER MEMBER	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8283	OUTPATIENT HOSP SPEECH THERAPY LIMIT 35 VIS 12 MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8284	OUTPATIENT HOSP PHYSICAL THERAPY LIM 20 VIS/12 MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8285	OUTPATIENT HOSP OCCUPTNL THERAPY LIM 20 VIS/12 MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8286	PHYSICIAN PHYSICAL THERAPY LIMIT 20 VISITS/12 MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8287	PHYSICIAN OCCUPATIONAL THERAPY LIMIT 20 VIS/12 MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8288	PHYSICIAN SPEECH THERAPY LIMIT 35 VISITS/12 MTHS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8289	SPEECH AND HEARING CENTER SPEECH THERAPY LIMIT 35	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8290	CHRONIC HOSP SPEECH THERAPY LIM 35 VIS OF 1 UNIT	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8291	CHRONIC HOSP SPEECH THERAPY LIM 35 VIS IN 12 MTHS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8292	CHRONIC HOSP OCCUPATIONAL THERAPY 20 VISITS/12MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8293	CHRONIC HOSP PHYSICAL THERAPY LIM 20 VISITS/12MTHS	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8294	REHAB CENTER PHYSICAL THERAPY LIMIT 20 VIS 12 MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8295	REHAB CENTER OCCUPTNL THERAPY LIMIT 20 VIS 12 MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8296	REHAB CENTER SPEECH THERAPY LIMIT 35 VISITS 12 MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8297	PSYCH INPATIENT LIMIT 30 CONSECTV DAYS PER EPISODE	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8298	PSYCH INPATIENT LIMIT 60 DAYS PER CALENDAR YEAR	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8299	OPERATING ROOM CONFLICTS W/AMBULATORY SURGERY	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8300	INDEPENDENT PHYSICAL THERAPY LIMIT 20 VIS 12 MONTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8301	INDEPENDENT OCCUPATIONAL THERAPY LIM 20 VIS 12 MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8302	ADULT & GROUP FOSTER CARE - LIMIT 31 UNITS PER MTH	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8303	PA REQUIRED FOR EQUIPMENT REPAIR OVER $1,000	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8400	NMLOA ALL LOC MAX 15 CUMULATIVE DAYS IN 1 DOS YEAR	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8401	NMLOA ALL LOC MAX 10 CUMULATIVE DAYS IN 1 DOS YEAR	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8500	2 CLAVICULECTOMIES IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8501	2 CLAVICULECTOMIES IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8502	2 CLAVICULECTOMIES IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8503	2 CLAVICULECTOMIES IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8504	2 AMPUTATIONS-WRIST IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8505	2 AMPUTATIONS-WRIST IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8506	2 AMPUTATIONS-WRIST IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8507	10 AMPUTATIONS-METACARPAL IN LIFE (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8508	10 AMPUTATIONS-METACARPAL IN LIFE (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8509	10 AMPUTATIONS-METACARPAL IN LIFE (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8510	10 AMPUTATIONS-METACARPAL IN LIFE (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8511	2 AMPUTATIONS-ANKLE IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8512	2 AMPUTATIONS-ANKLE IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8513	2 AMPUTATIONS-ANKLE IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8514	2 AMPUTATION-FOOT (MID) IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8515	2 AMPUTATION-FOOT (MID) IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8516	2 AMPUTATION-FOOT (MID) IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8517	2 AMPUTATION-FOOT (TRN) IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8518	2 AMPUTATION-FOOT (TRN) IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8519	2 AMPUTATION-FOOT (TRN) IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8520	1 EPIGLOTTIDECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8521	1 EPIGLOTTIDECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8522	1 EPIGLOTTIDECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8523	1 EPIGLOTTIDECTOMY IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8524	1 COLPECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8525	1 COLPECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8526	1 COLPECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8527	1 TRACHELECTOMY (CERVIECTOMY) IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8528	1 TRACHELECTOMY (CERVIECTOMY) IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8529	1 TRACHELECTOMY (CERVIECTOMY) IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8530	1 TRACHELECTOMY (CERVIECTOMY) IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8531	1 THYROIDECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8532	1 THYROIDECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8533	1 THYROIDECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8534	1 EVALUATION (99456) PER PROVIDER IN LIFETIME	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8535	2 MASTECTOMIES IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8536	2 MASTECTOMIES IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8537	2 MASTECTOMIES IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8538	2 MASTECTOMIES IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8539	1 MASTECTOMY IN LIFETIME-MOD 50 (INACTIVE)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8540	1 MASTECTOMY IN LIFETIME-MOD 50 (INACTIVE)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8541	10 AMPUTATIONS-FINGER IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8542	10 AMPUTATIONS-FINGER IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8543	10 AMPUTATIONS-FINGER IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8544	2 AMPUTATIONS-ARM IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8545	2 AMPUTATIONS-ARM IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8546	2 AMPUTATIONS-ARM IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8547	2 AMPUTATIONS FOREARM-THRU RADIUS & ULNA (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8548	2 AMPUTATIONS FOREARM-THRU RADIUS & ULNA (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8549	2 AMPUTATIONS FOREARM-THRU RADIUS & ULNA (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8550	2 AMPUTATIONS-LEG IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8551	2 AMPUTATIONS-LEG IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8552	2 AMPUTATIONS-LEG IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8553	2 AMPUTATIONS LEG- TIBIA & FIBULA- LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8554	2 AMPUTATIONS LEG- TIBIA & FIBULA- LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8555	2 AMPUTATIONS LEG- TIBIA & FIBULA- LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8556	1 LARYNGECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8557	1 LARYNGECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8558	1 LARYNGECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8559	1 HEMILARYNGECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8560	1 HEMILARYNGECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8561	1 HEMILARYNGECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8562	1 TOTAL PNEUMONECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8563	1 TOTAL PNEUMONECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8564	1 TOTAL PNEUMONECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8565	1 GLOSSECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8566	1 GLOSSECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8567	1 GLOSSECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8568	1 APPENDECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8569	1 APPENDECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8570	1 APPENDECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8571	1 TOTAL GASTRECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8572	1 TOTAL GASTRECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8573	1 TOTAL GASTRECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8574	1 AMPUTATION-PENIS IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8575	1 AMPUTATION-PENIS IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8576	1 AMPUTATION-PENIS IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8577	1 CIRCUMCISION IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8578	1 CIRCUMCISION IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8579	1 CIRCUMCISION IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8580	1 CIRCUMCISION IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8581	2 ORCHIECTOMIES-UNILAT IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8582	2 ORCHIECTOMIES-UNILAT IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8583	2 ORCHIECTOMIES-UNILAT IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8584	2 ORCHIECTOMIES-UNILAT IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8585	1 ORCHIECTOMY- BILATERAL IN LIFETIME (INACTIVE)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8586	1 ORCHIECTOMY- BILATERAL IN LIFETIME (INACTIVE)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8587	1 PROSTATECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8588	1 PROSTATECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8589	1 PROSTATECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8590	1 VULVECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8591	1 VULVECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8592	1 VULVECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8593	1 VULVECTOMY IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8594	1 EXCISION OF CERVICAL STUMP IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8595	1 EXCISION OF CERVICAL STUMP IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8596	1 EXCISION OF CERVICAL STUMP IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8597	1 TRACHELECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8598	1 TRACHELECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8599	1 TRACHELECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8600	1 TRACHELECTOMY IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8601	1 HYSTERECTOMY IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8602	1 HYSTERECTOMY IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8603	1 HYSTERECTOMY IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8604	2 ADRENALECTOMIES IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8605	2 ADRENALECTOMIES IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8606	2 ADRENALECTOMIES IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8607	1 ADRENALECTOMY IN LIFETIME (INACTIVE)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8608	2 COMPLETE IRIDECTOMIES IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8609	2 COMPLETE IRIDECTOMIES IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8610	2 COMPLETE IRIDECTOMIES IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8611	2 COMPLETE IRIDECTOMIES IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8612	1 PALATOPLASTY FOR CLEFT PALATE IN LIFETIME (SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8613	1 PALATOPLASTY FOR CLEFT PALATE IN LIFETIME (ASSIST SURG)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
8614	1 PALATOPLASTY FOR CLEFT PALATE IN LIFETIME (OPD FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
8615	1 PALATOPLASTY FOR CLEFT PALATE IN LIFETIME (ASC FACILITY)	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
9000	PHARMACY ALLOWED AMOUNT IS LESS THAN BILLED AMOUNT	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
9001	REIMBURSEMENT REDUCED BY THE RECIPIENT'S CO-PAYMENT AMOUNT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
9002	PRICING METHOD MISSING/INVALID FOR CLAIM TYPE	585	DENIED CHARGE OR NON-COVERED CHARGE	-	-
9005	CLAIM PAYMENT AMOUNT LESS THAN COPAY AMOUNT	66	PAYMENT REFLECTS USUAL AND CUSTOMARY CHARGES	-	-
9010	MEMBER HAS MET COPAY CAP	639	RESPONSIBILITY AMOUNT	QC	PATIENT
9011	CO-PAYMENT INCLUSION CRITERIA NOT MET	639	RESPONSIBILITY AMOUNT	-	-
9013	MEMBER CALENDAR COINSURANCE LIMIT EXCEEDED	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
9015	AT LEAST ONE DETAIL IS IN DENIED STATUS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
9016	CLAIM DENIED BECAUSE ALL DETAILS DENIED	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
9020	CRITICAL EDIT IS RECYCLED TO A PAY EDIT	0	CANNOT PROVIDE FURTHER STATUS ELECTRONICALLY	-	-
9050	COLLECTION FROM TITLE 18(MEDICARE PART-A) FOR SERVICES PREVIOUSLY PAID BY MCARE	550	COORDINATION OF BENEFITS CODE	-	-
9051	COLLECTION FROM TITLE 18(MEDICARE PART-B) FOR SERVICES PREVIOUSLY PAID BY MCARE	550	COORDINATION OF BENEFITS CODE	-	-
9052	COLLECTION FROM ANY HEALTH INSURANCES	550	COORDINATION OF BENEFITS CODE	-	-
9053	COLLECTION FROM CASUALTY INSURANCE, WORKMANS COMP, OR TORT LIABILITY CLAIMS	550	COORDINATION OF BENEFITS CODE	-	-
9054	COLLECTION FROM ESTATE OF DECEASED MEMBER	550	COORDINATION OF BENEFITS CODE	-	-
9055	MANUAL ADJUSTMENT	101	CLAIM PROCESSED AS ADJUSTMENT TO PREVIOUS CLM	-	-
9056	GENERAL MASS ADJUSTMENT	101	CLAIM PROCESSED AS ADJUSTMENT TO PREVIOUS CLM	-	-
9057	PAID TO WRONG PROVIDER	153	ENTITY'S ID NUMBER	1P	PROVIDER
9058	PAID FOR WRONG MEMBER	153	ENTITY'S ID NUMBER	QC	PATIENT
9059	PROVIDER BILLED SERVICE PRIOR TO SERVICE DATE/SERVICE NOT DELIVERED	187	DATE(S) OF SERVICE	-	-
9060	DUPLICATE PAYMENT RETURNED DUE TO AN ERRONEOUS DUPLICATE PAYMENT FOR SAME DATE	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
9061	DUPLICATE PAYMENT - PROVIDER BILLED TWICE	54	DUPLICATE OF PREVIOUSLY PROCESSED CLAIM/LINE	-	-
9062	COLLECTION FROM CREDIT BALANCE ON MEMBERS ACCOUNTS	631	REIMBURSEMENT RATE	-	-
9063	PROVIDER PAID MORE THAN BILLED	631	REIMBURSEMENT RATE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
9064	PROVIDER ONLY PERFORMED COMPONENT OF SERVICE BILLED	631	REIMBURSEMENT RATE	-	-
9065	OTHER	55	CLAIM ASSIGNED TO AN APPROVER/ANALYST	-	-
9066	PATIENT PAID AMOUNT DISCREPANCY	639	RESPONSIBILITY AMOUNT	-	-
9067	COLLECTION FROM TITLE 18 WHEN PART A OR B CANNOT BE DETERMINED	550	COORDINATION OF BENEFITS CODE	-	-
9068	LEAVE OF ABSENCE DAYS WERE EITHER NOT INDICATED OR INCORRECT	258	DAYS/UNITS FOR PROCEDURE/REVENUE CODE	-	-
9069	OUTPATIENT CLAIM WAS BILLED DURING AN INPATIENT STAY	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
9070	OUTPATIENT CLAIM WAS BILLED DURING AN INPATIENT STAY - SAME FACILITY	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
9071	LONG TERM CARE CLAIM WAS BILLED DURING A HOSPICE SEGMENT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
9072	CLAIM WAS PAID AN INCORRECT PRICE	183	AMOUNT ENTITY HAS PAID	-	-
9073	MEDICAL RECORD WAS NOT SUBMITTED FOR POST-PAYMENT REVIEW	294	SUPPORTING DOCUMENTATION	-	-
9074	MEDICAL NECESSITY WAS NOT DETERMINED BY POST-PAYMENT REVIEW	287	MEDICAL NECESSITY FOR SERVICE	-	-
9075	CLAIM WAS VOIDED AFTER MEDICAL REVIEW	46	INTERNAL REVIEW/AUDIT	-	-
9076	ADJUSTMENT DUE TO RETROACTIVE MANAGED CARE ENROLLMENT	101	CLAIM PROCESSED AS ADJUSTMENT TO PREVIOUS CLM	-	-
9077	CLAIM REJECTED BY MASSHEALTH	104	PROCESSED ACCORDING TO PLAN PROVISIONS		
9084	MANUAL ADJUSTMENT BY BATCH	101	CLAIM PROCESSED AS ADJUSTMENT TO PREVIOUS CLM	-	-
9100	90 DAY WAIVER DENIED. THE MASSHEALTH REMITTANCE ADVICE REFERENCED IN YOUR LETTER IS MISSING	46	INTERNAL REVIEW/AUDIT	-	-
9103	90 DAY WAIVER DENIED. THE MASSHEALTH REMITTANCE ADVICE PROVIDED DOES NOT PERTAIN TO THE CLAIMS SUBMITTED	46	INTERNAL REVIEW/AUDIT	-	-
9106	90 DAY WAIVER DENIED. THE MASSHEALTH REMITTANCE ADVICE PROVIDED BELONGS TO A CLAIM THAT IS IN SUSPENSE	46	INTERNAL REVIEW/AUDIT	-	-
9109	90 DAY WAIVER DENIED. THE MASSHEALTH REMITTANCE ADVICE PROVIDED BELONGS TO A CLAIM THAT HAS ALREADY PAID	46	INTERNAL REVIEW/AUDIT	-	-
9112	90 DAY WAIVER DENIED. THE EXPLANATION OF BENEFITS (EOB) FROM THE OTHER INSURER IS MISSING	46	INTERNAL REVIEW/AUDIT	-	-
9115	90 DAY WAIVER DENIED. A COPY OF THE RETROACTIVE ENROLLMENT NOTICE IS MISSING	46	INTERNAL REVIEW/AUDIT	-	-
9118	90 DAY WAIVER DENIED. DOCUMENTATION PROVIDED DOES NOT MATCH THE NAME(S) AND/OR DATES OF SERVICE(S) ON THE CLAIMS	46	INTERNAL REVIEW/AUDIT	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
9121	90 DAY WAIVER DENIED. A COPY OF THE REGISTRATION/ ADMISSION FORM THAT REFLECTS MASSHEALTH INFORMATION WAS NOT PROVIDED ON THE SERVICE DATE IS MISSING OR INCOMPLETE	46	INTERNAL REVIEW/AUDIT	-	-
9124	90 DAY WAIVER DENIED. A COPY OF A STATEMENT/BILL SENT TO THE MEMBER IS MISSING	46	INTERNAL REVIEW/AUDIT	-	-
9127	90 DAY WAIVER DENIED. A COPY OF THE RETROACTIVE PRIOR AUTHORIZATION NOTICE IS MISSING	46	INTERNAL REVIEW/AUDIT	-	-
9130	90 DAY WAIVER DENIED. A COPY OF THE RETROACTIVE PRE-ADMISSION SCREENING NOTICEIS MISSING	46	INTERNAL REVIEW/AUDIT	-	-
9133	90 DAY WAIVER DENIED. A COPY OF THE NOTIFICATION OF BIRTH (NOB) OR ENROLLMENT NOTICE IS MISSING	46	INTERNAL REVIEW/AUDIT	-	-
9136	90 DAY WAIVER DENIED. A COPY OF THE PIP EXHAUSTION NOTICE IS MISSING	46	INTERNAL REVIEW/AUDIT	-	-
9139	90 DAY WAIVER DENIED. THE SERVICE DATE EXCEEDS ONE YEAR	46	INTERNAL REVIEW/AUDIT	-	-
9142	90 DAY WAIVER DENIED. THE SERVICE DATE EXCEEDS 18 MONTHS	46	INTERNAL REVIEW/AUDIT	-	-
9145	90 DAY WAIVER DENIED. 90 DAY WAIVER IS NOT REQUIRED BECAUSE THIS IS AN ADJUSTMENT TO A PREVIOUSLY PAID CLAIM. REFER TO THE BILLING INSTRUCTIONS FOR INFORMATION REGARDING THE SUBMISSION OF ADJUSTMENT CLAIMS	46	INTERNAL REVIEW/AUDIT	-	-
9148	90 DAY WAIVER DENIED. 90 DAY WAIVER IS NOT REQUIRED BECAUSE THIS IS A RESUBMITTAL CLAIM. REFER TO THE BILLING INSTRUCTIONS FOR INFORMATION REGARDING THE RESUBMISSION OF CLAIMS	46	INTERNAL REVIEW/AUDIT	-	-
9151	90 DAY WAIVER DENIED. A COPY OF THE ELIGIBILITY VERIFICATION PRINTOUT REFERENCED IN YOUR LETTER IS MISSING	46	INTERNAL REVIEW/AUDIT	-	-
9154	90 DAY WAIVER DENIED. REQUEST DOES NOT COMPLY WITH MASSHEALTH REGULATIONS	46	INTERNAL REVIEW/AUDIT	-	-
9157	90 DAY WAIVER DENIED. THE MEMBER'S ID WAS NOT CHANGED	46	INTERNAL REVIEW/AUDIT	-	-
9160	90 DAY WAIVER DENIED. THE ORIGINAL EDI CLAIM(S) WERE NOT RECEIVED TIMELY	46	INTERNAL REVIEW/AUDIT	-	-
9163	90 DAY WAIVER DENIED. THE ORIGINAL EDI CLAIM(S) WERE RECEIVED TIMELY AND CAN BE RESUBMITTED	46	INTERNAL REVIEW/AUDIT	-	-
9166	90 DAY WAIVER DENIED. THE ORIGINAL EDI CLAIM(S) REFERENCED IN YOUR LETTER COULD NOT BE LOCATED. PLEASE RESUBMIT TO THE 90 DAY WAIVERS UNIT WITH ADDITIONAL DOCUMENTATION	46	INTERNAL REVIEW/AUDIT	-	-
9700	CLAIM WAS DENIED DUE TO A POS REVERSAL	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-

MassHealth Crosswalk of EOB Codes to HIPAA Claim Status Codes and Entity Codes

EOB CODE	EOB CODE DESCRIPTION	CLAIM STATUS CODE	CLAIM STATUS CODE DESCRIPTION	ENTITY ID CODE	ENTITY ID CODE DESCRIPTION
9701	MEMBER LINKING CLAIM ADJUSTMENT	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
9702	PROVIDER RECOUPED CLAIM	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
9800	MAXIMUM PAYMENT ALLOWED FOR HMO/COV	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
9875	NON-MEDICAL LEAVE DAYS LIMIT EXCEEDED	483	MAXIMUM COVERAGE AMOUNT MET OR EXCEEDED FOR BENEFIT PERIOD	-	-
9901	REIMBURSEMENT LIMITED TO ONE SET OF FRAMES PER YEAR FOR RECIPIENTS 18 YEARS	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
9905	PRICE REDUCED TO SPAD PAYMENT	66	PAYMENT REFLECTS USUAL AND CUSTOMARY CHARGES	-	-
9907	TPL AMOUNT APPLIED	20	ACCEPTED FOR PROCESSING	-	-
9908	PHARMACY PRICING APPLIED	104	PROCESSED ACCORDING TO PLAN PROVISIONS	-	-
9909	50 PERCENT OF AMOUNT BILLED APPLIED	20	ACCEPTED FOR PROCESSING	-	-
9910	PHARMACY DISPENSING FEE APPLIED	20	ACCEPTED FOR PROCESSING	-	-
9911	PRICING ADJUSTMENT - LONG TERM CARE PRICING APPLIED	0	CANNOT PROVIDE FURTHER STATUS ELECTRONICALLY	-	-
9916	UCC RATE PRICING APPLIED	20	ACCEPTED FOR PROCESSING	-	-
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	20	ACCEPTED FOR PROCESSING	-	-
9919	PROVIDER LEVEL OF CARE PRICING APPLIED	20	ACCEPTED FOR PROCESSING	-	-
9920	RBRVS (RESOURCE-BASED RELATIVE VALUE SCALE) PRICING APPLIED	20	ACCEPTED FOR PROCESSING	-	-
9921	PA (PRIOR AUTHORIZATION) PRICING APPLIED	20	ACCEPTED FOR PROCESSING	-	-
9922	SPENDDOWN DEDUCTIBLE APPLIED	20	ACCEPTED FOR PROCESSING	-	-
9926	CLAIM HAS CUTBACK AMOUNT	20	ACCEPTED FOR PROCESSING	-	-
9928	COB-TPL COST SAVINGS	1	FOR MORE DETAILED INFORMATION, SEE REMITTANCE ADVICE	-	-
9932	PRICING ADJUSTMENT - DRG PRICING APPLIED	107	PROCESSED ACCORDING TO CONTRACT/PLAN PROVISIONS	-	-
9933	AMOUNT CUTBACK DUE TO APC PRICING	66	PAYMENT REFLECTS USUAL AND CUSTOMARY CHARGES	-	-
9997	PERSONAL RESOURCES DEDUCTED FROM THE CLAIM ARE A RESULT OF PREVIOUS RESOURCES COLLECTED FOR THE RECIPIENT IN THE SAME MONTH	639	RESPONSIBILITY AMOUNT	-	-
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT HEALTH COVERAGE PROGRAM POLICIES	66	PAYMENT REFLECTS USUAL AND CUSTOMARY CHARGES	-	-