MassHealth List of EOB Codes Appearing on the Remittance Advice

EOB CODE	EOB DESCRIPTION
0201	BILLING PROVIDER ID NUMBER MISSING
0202	BILLING PROVIDER ID IN INVALID FORMAT
0203	MEMBER I.D. NUMBER MISSING/INVALID
0204	HOSPITAL DISCHARGE DATE INVALID
0205	PRESCRIBING PRACTITIONER S LICENSE NO. MISSING
0206	PRESCRIBING PRACTITIONR LICENSE NO. FORMAT INVALID
0208	PREGNANCY INDICATOR INVALID
0210	BRAND MEDICALLY NECESSARY INDICATOR INVALID
0211	REFILL INDICATOR INVALID
0212	PRESCRIPTION NUMBER IS MISSING
0213	DATE PRESCRIBED IS MISSING
0214	DATE PRESCRIBED IS INVALID
0215	DATE DISPENSED IS MISSING
0216	DATE DISPENSED IS INVALID
0217	NDC MISSING
0218	NDC INVALID FORMAT
0219	QUANTITY DISPENSED IS MISSING
0220	QUANTITY DISPENSED IS INVALID
0221	DAYS SUPPLY MISSING
0222	DAYS SUPPLY INVALID
0223	PROC CODE REQUIRES DIAGNOSIS CODE, NONE FOUND ON CLAIM
0224	DIAGNOSIS TREATMENT INDICATOR INVALID
0225	MISSING PRESCRIBING PROVIDER NUMBER
0226	REFERRAL PROV ID REQUIRED FOR PROCEDURE GROUP
0227	THIRD PARTY PAYMENT AMOUNT INVALID
0228	BILLING PROVIDER SIGNATURE MISSING
0229	SOURCE OF ADMISSION MISSING
0231	RENDERING PROVIDER NUMBER IS MISSING
0233	UNITS OF SERVICE MISSING
0234	PROCEDURE CODE MISSING
0235	PROCEDURE CODE NOT IN VALID FORMAT
0236	DETAIL DOS DIFFERENT THAN THE HEADER DOS
0237	OUTPATIENT CLAIMS CANNOT SPAN DATES
0238	MEMBER NAME IS MISSING
0239	THE DETAIL "TO" DATE OF SERVICE IS MISSING
0240	THE DETAIL "TO" DATE IS INVALID
0241	ACCIDENT INDICATOR IS INVALID
0242	SECONDARY DIAGNOSIS CODE INVALID FORMAT
0243	MISSING MEDICARE PAID DATE
0244	THIRD DIAGNOSIS CODE INVALID
0245	MISSING OCCURRENCE CODE
0246	FOURTH DIAGNOSIS CODE INVALID
0248	PLACE OF SERVICE IS MISSING OR BLANK
0249	PLACE OF SERVICE IS INVALID
0250	CLAIM HAS NO DETAILS

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EOB CODE	EOB DESCRIPTION
0251	FIRST MODIFIER NOT COVERED
0252	SECOND MODIFIER NOT COVERED
0253	THIRD MODIFIER NOT COVERED
0254	BILLING PROVIDER LOCATION CODE MISSING
0255	BILLING PROVIDER LOCATION CODE INVALID
0256	MISSING MEDICARE PAID DATE - DETAIL
0257	PLACE OF SERVICE IS INVALID - DETAIL
0258	PRIMARY DIAGNOSIS CODE MISSING
0259	DATE BILLED IS MISSING/INVALID
0260	UNITS OF SERVICE NOT IN VALID FORMAT
0261	TOOTH NUMBER MISSING
0262	TOOTH NUMBER INVALID
0263	TOOTH SURFACE CODE INVALID
0264	DETAIL FROM DATE OF SERVICE IS MISSING
0265	DETAIL FROM DATE OF SERVICE IS INVALID
0266	INSUFFICIENT NUMBER OF VALID TOOTH SURFACE CODES
0268	BILLED AMOUNT MISSING
0269	DETAIL BILLED AMOUNT INVALID
0270	HEADER TOTAL BILLED AMOUNT MISSING
0271	HEADER TOTAL BILLED AMOUNT INVALID
0272	PRIMARY DIAGNOSIS CODE INVALID
0273	TYPE OF BILL MISSING
0274	TYPE OF BILL CODE INVALID
0275	ADMIT DATE MISSING
0276	ADMIT DATE INVALID
0277	ADMIT HOUR INVALID
0278	ADMIT TYPE MISSING
0279	INVALID TYPE OF ADMISSION
0280	PATIENT STATUS IS MISSING
0281	PATIENT STATUS IS INVALID
0282	COVERED DAYS MISSING
0283	COVERED DAYS INVALID
0284	PRIMARY CONDITION CODE INVALID
0285	SECOND CONDITON CODE INVALID
0286	THIRD CONDITION CODE INVALID
0287	FOURTH CONDITION CODE INVALID
0288	FIFTH CONDITION CODE INVALID
0289	SIXTH CONDITION CODE INVALID
0290	SEVENTH CONDITION CODE INVALID
0291	REVENUE CODE 183 REQUIRES OSC = 74
0292	REVENUE CODE 185 REQUIRES OSC = 71
0301	PAYER RESPONSIBILTY/OTHER PAYER COUNT MISMATCH
0302	INSURED GROUP NAME (HSN TYPE) IS MISSING OR INVALID
0303	DESTINATION PAYER ID MUST BE 995
0304	PYR RESPONSIB AND INSURED GRP NAME NOT COMPATIBLE

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EOB CODE	EOB DESCRIPTION
0305	G1 REF REQUIRED WHEN HSN INSURED GROUP IS CA OR MH
0308	AID CAT MUST BE HB WHEN INSURED GROUP IS BD
0309	AID CAT MUST BE HC OR HD WHEN INSURED GROUP IS CA
0310	AID CAT MUST BE HA WHEN INSURED GROUP IS MH
0315	HSN PARTIAL CLM PAT RESPONSIBILITY AMT NOT PRESENT
0320	INVALID TOB FOR HSN
0327	HSN MH CLAIM SUBMISSION >18 MONTHS FROM LDOS
0330	HSN BD CLAIM SUBMISSION <= 120 DAYS FROM DOS
0335	OCCURRENCE CODE A2 REQUIRED ON HSN BD CLAIM
0339	REVENUE CODE IS MISSING
0340	REVENUE CODE IS INVALID
0343	CERTIFICATION CODE INVALID
0347	PAYER PRIOR PAYMENT IS INVALID
0350	NO. OF DETAILS NOT EQUAL TO SUBMITTED DETAIL COUNT
0351	REFILL NOT ALLOWED FOR NARCOTIC DRUGS
0355	FIFTH DIAGNOSIS CODE INVALID
0356	SIXTH DIAGNOSIS CODE INVALID
0357	SEVENTH DIAGNOSIS CODE INVALID
0358	EIGHTH DIAGNOSIS CODE INVALID
0359	NINTH DIAGNOSIS CODE INVALID
0360	TENTH DIAGNOSIS CODE INVALID
0361	ELEVENTH DIAGNOSIS CODE INVALID
0362	TWELFTH DIAGNOSIS CODE INVALID
0363	PRINCIPAL ICD9 PROCEDURE CODE IS INVALID
0365	PRINCIPAL PROCEDURE DATE INVALID
0366	FIRST OTHER PROCEDURE CODE INVALID
0368	FIRST OTHER PROCEDURE DATE INVALID
0369	SECOND OTHER PROCEDURE CODE INVALID
0371	SECOND OTHER PROCEDURE DATE INVALID
0372	THIRD OTHER PROCEDURE CODE INVALID
0375	FOURTH OTHER PROCEDURE CODE INVALID
0378	FIFTH OTHER PROCEDURE CODE INVALID
0382	ATTENDING PHYSICIAN ID INVALID
0383	FIRST OTHER PHYSICIAN ID INVALID
0389	REVENUE CODE REQUIRES A CORRESPONDING HCPCS/CPT4
0391	MEDICARE DEDUCTIBLE AMOUNT MISSING-DETAIL
0392	MEDICARE PAID AMOUNT NOT NUMERIC-DETAIL
0393	MEDICARE DEDUCTIBLE AMOUNT MISSING
0394	MEDICARE CO-INSURANCE AMOUNT MISSING
0395	HEADER STATEMENT COVERS PERIOD "FROM" DATE MISSING
0396	HEADER STATEMENT COVERS PERIOD "FROM" DATE INVALID
0397	HEADER STMT COVERS PERIOD "THROUGH" DATE MISSING
0398	STATEMENT COVERS PERIOD "THROUGH" DATE INVALID
0400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO
0401	PRESENT ON ADMISSION INDICATOR MISSING

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EOB CODE	EOB DESCRIPTION
0402	PRESENT ON ADMISSION INDICATOR INVALID
0403	PRESENT ON ADMISSION IND PRESENT WHERE NOT ALLOWED
0405	PAID PAPE WITH 0 ALLOWED UNITS
0427	ACCIDENT DATE INVALID
0431	DEDUCTIBLE AMOUNT INVALID-DETAIL
0432	COINSURANCE AMOUNT INVALID-DETAIL
0433	MEDICARE DEDUCTIBLE AMOUNT INVALID
0434	MEDICARE COINSURANCE AMOUNT INVALID
0436	TOTAL MEDICARE ALLOWED AMOUNT INVALID
0437	MEDICARE PSYCH ADJUSTMENT AMOUNT INVALID
0438	TOTAL MEDICARE ALLOWED AMOUNT INVALID-DETAIL
0439	PSYCH ADJUSTMENT (PR122) AMOUNT INVALID-DETAIL
0440	MCARE PAID 100% OF CLAIM-HEADER
0441	MCARE PAID 100% OF CLAIM-DETAIL
0442	MEDICARE PAID AMOUNT NOT NUMERIC-HEADER
0443	MEDICARE PAID AMOUNT NOT NUMERIC-DETAIL
0444	MEDICARE APPROVED AMOUNT = 0 - HEADER
0445	MEDICARE APPROVED AMOUNT = 0 - DETAIL
0450	INVALID QUADRANT
0452	DTL RENDERING/PERFORMING PROVIDER SERV LOC MISSING
0453	HDR RENDERING/PERFORMING PROVIDER SERV LOC MISSING
0454	INVALID ASSIGNMENT CODE
0456	INVALID PROCEDURE TYPE ACC. TO PROCEDURE QUALIFIER
0457	INVALID PRINCIPAL/OTHER PROCEDURE TYPE
0458	DIAGNOSIS CODE 10 - 24 INVALID
0459	DETAIL DIAGNOSIS TREATMENT INDICATOR INVALID
0461	VALUE CODE IS INVALID
0462	VALUE CODE AMOUNT IS MISSING
0463	VALUE CODE AMOUNT IS INVALID
0471	CONDITION CODE 8-24 INVALID
0473	ICD9 PROCEDURE 7-24 INVALID
0474	ICD-9 PROCEDURE 7-24 OR DATE MISSING
0475	ICD9 PROCEDURE 7-24 DATE IS INVALID
0476	DETAIL ATTENDING PHYSICIAN ID IS INVALID
0477	DETAIL FIRST "OTHER PHYSICIAN" ID IS INVALID
0478	0478-BILL CPT CODES TO MASSHEALTH ON CMS 1500 FORM
0481	MLOA DAYS GREATER THAN HEADER DAYS
0484	LOA OSC DATES CANNOT SPAN ACROSS DIFFERENT MONTHS
0485	TO DATE IS LESS THAN FROM DATE FOR OCCUR SPAN
0486	MLOA DAYS AND DAYS BETWEEN FROM AND TO DOS NOT EQUAL
0487	NMLOA DAYS AND DAYS BETWEEN FROM AND TO DOS NOT SAME
0488	MLOA OSC DAYS SPANNED > DETAIL FROM AND TO DOS
0489	THE OCCURRENCE SPAN FROM DATE IS INVALID
0490	THE OCCURRENCE SPAN TO DATE IS INVALID
0491	DIFFERNT MLOA DAYS CANNOT OVERLAP FROM AND TO DAYS

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EOB CODE	EOB DESCRIPTION
0492	DIFFERNT NMLOA DAYS CANT OVERLAP FROM AND TO DAYS
0493	MLOA AND NMLOA DAYS CANT OVERLAP FROM AND TO DAYS
0494	OCCURRENCE SPAN LOA DATES NOT WITHIN CLAIM DATES
0495	THIS LTC CLAIM HAS LOA DAYS, BUT PROV TYPE WRONG
0496	OCCURRENCE SPAN FROM DATE MISSING
0497	OCCURRENCE SPAN TO DATE MISSING
0498	THE OCCURRENCE CODE IS INVALID
0500	DATE PRESCRIBED AFTER BILLING DATE
0502	DATE DISPENSED EARLIER THAN DATE PRESCRIBED
0503	DATE DISPENSED AFTER BILLING DATE
0506	ICN DATE PRIOR TO DATE BILLED
0507	THE DETAIL "FROM" DATE IS AFTER THE "TO" DATE
0508	TOTAL CHARGE DOES NOT EQUAL THE SUM OF ALL DETAILS
0509	NET BILLED OUT OF BALANCE
0512	CLAIM PAST 12 MONTH FILING LIMIT
0514	HEADER THRU DATE OF SERVICE AFTER ICN DATE
0518	COVERED DAYS EXCEED STATEMENT PERIOD
0519	ADMIT DATE IS AFTER STATEMENT PERIOD "FROM" DATE
0520	INVALID REVENUE CODE/PROCEDURE CODE COMBINATION
0521	THRU DOS LATER THAN DISCHARGE DATE
0526	HEADER FROM DOS IS AFTER HEADER THROUGH DATE
0527	DETAIL FROM DATE OF SERVICE IS AFTER ICN DATE
0529	SURGERY DATE IS BEFORE THE ADMIT DATE
0530	SURGERY DATE IS AFTER THE DISCHARGE DATE
0532	REVENUE CODE/PROVIDER SPECIALTY MISMATCH
0542	MEMBER INELIGIBLE SERV DATE
0545	FINAL DEADLINE EXCEEDED
0550	ADJUSTMENT FAILED
0551	DISPOSITION AMT FOR ADJUSTMENT IS LESS THAN ZERO
0552	PROVIDER MAY NOT ADJUST GENERATED ATP/PAPE CLAIM
0553	ADJUSTMENT NPI TRANSLATION ISSUE
0554	HEADER BILLED DATE IS PRIOR TO DATES OF SERVICE
0555	CLAIM PAST 24 MONTH FILING DEADLINE- DETAIL
0556	CLAIM PAST 24 MONTH FILING DEADLINE- HEADER
0557	COINS AND DEDUCT AMT MISSING - DTL
0558	COINSURANCE AND DEDUCT AMT MISSING
0559	M-CARE COIN AMT GREATER THAN M-CARE PAID AMT-HDR
0560	M-CARE COINSURANCE AMT GREATER THAN THE AMOUNT PAID
0568	HEADER DISCHARGE DATE IS LESS THAN ADMIT DATE
0569	HDR DTE OF ACCIDENT GREATER THAN LAST DTE OF SERV
0570	HEADER TOTAL DAYS LESS THAN COVERED DAYS
0571	DETAIL SURGICAL PROCEDURE MISSING
0572	ROOM AND BOARD DAYS CONFLICT
0574	SERV DATES ARE NOT IN SAME MONTH-HEADER
0575	SURGERY DTE CANNOT BE OUTSIDE HDR DATES OF SERVICE

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EOB CODE	EOB DESCRIPTION
0576	CLAIM HAS THIRD-PARTY PAYMENT
0577	SERV DATES ARE NOT IN SAME MONTH-DETAIL
0585	ADMIT DATE NOT EQ TO 1ST DATE OF SERV FOR REV/DIAG COMB
0589	SUSPEND ADJUSTMENT FOR REVIEW
0590	DAYS OVERLAPP FISCAL YEAR END/BEGIN DATES
0594	UNITS/DOS CONFLICT
0599	ATTACHMENT CONTROL NUMBER MISSING
0600	UNITS NOT EQUAL TO QUADRANTS BILLED
0601	TEETH NOT BILLABLE WITH QUADRANTS
0602	UNITS NOT EQUAL TO TEETH BILLED
0610	LOC NOT COMPATIBLE WITH LEAVE DAYS
0616	COMPONENT OF STAY EXCEEDED
0617	MEMBER AGE/PROGRAM CONFLICT
0618	NO OUTLIER DAYS FOR HSNI
0619	INVALID TYPE OF CLAIM FOR HSNI
0620	OCCURRENCE CODE 47 FDOS IS INVALID FOR HSNI
0621	MISSING/INVALID K3 SEGMENT FOR HSN
0622	INVALID INSURED GROUP NAME/K3 RECORD TYPE FOR HSN
0623	INVALID K3 REFERENCE ID FOR HSN
0624	INVALID K3 TERMS DISCOUNT FOR HSN RECORD TYPE 06
0625	INVALID K3 PARTIAL START DATE FOR HSN
0626	INVALID INSURED GROUP NAME/K3 RECORD TYPE FOR HSN
0627	INVALID INSURED GROUP NAME/K3 REFERENCE ID FOR HSN
0629	INVALID K3 WRITE-OFF DATE FOR HSN
0634	A3 OCC CODE REPORTED, HSN CLAIM MUST BE PRIMARY
0636	B3 OCC CODE REPORTED, HSN CLAIM MUST BE SECONDARY
0637	C3 OCC CODE REPORTED, HSN CLAIM MUST BE TERTIARY+
0643	INVALID OTHER COVERAGE CODE
0700	MULTIPLE PRIMARY ENDOSCOPIC FAMILIES CANNOT BE BILLED
0701	NO PRIMARY SURGICAL PROCEDURE INDICATED
0702	ENDOSCOPIC PRICE AMOUNT LESS THAN ZERO.
0703	ENDO FAMILY MIXED PRIMARY/SECONDARY
0799	INVALID DISPENSE STATUS
0800	HCPCS REQUIRES NDC
0801	SPECIAL HANDLING EDIT
0802	SPECIAL HANDLING EDIT WITH CRITICAL ERROR
0803	GENERIC SPECIAL HANDLING
0804	GENERIC SPECIAL PAY
0805	INVALID SPECIAL HANDLING CODE
0806	NOTE REQUIRED FOR PREEMPTIVE ESC - DETAIL
0807	NOTE REQUIRED FOR PREEMPTIVE ESC - HEADER
0808	CLERK ID REQUIRED FOR PREEMPTIVE ESC
0809	CLERK ID REQUIRED FOR PREEMPTIVE ESC
0810	INVALID SUBMITTER ID
0811	INVALID SUBMITTER ID/BILLING PROVIDER COMBINATION

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EOB CODE	EOB DESCRIPTION
0812	NO PCC SELECTED
0813	SPECIAL PAY PRICED AT ZERO
0814	HIC NUMBER NOT PRESENT ON CLAIM
0815	TYPE OF BILL MUST MATCH PATIENT STATUS
0816	DISALLOW ROOM AND BOARD FOR LATE CHARGES
0817	INVALID DISCHARGE DATE
0818	SPCL HANDLING 90 DAY WAIVER
0819	SUSPEND CLAIM FOR TPL REVIEW
0820	NDC GIVEN WITH NO/INVALID UNITS FOR HCPCS
0821	NDC GIVEN WITH NO/INVALID MEASUREMENT FOR HCPCS
0822	NDC GIVEN WITH NO/INVALID UNIT PRICE FOR HCPCS
0823	NO PCC SELECTED
0828	CLAIM/ APPEAL IS UNDER REVIEW
0829	NCCI APPEAL/SPECIAL HANDLE UNDER REVIEW
0830	GROUPER UNABLE TO ASSIGN DRG TO CLAIM
0831	3M GRP - DIAGNOSIS CODE CANNOT BE USED AS PRINCIPAL DIAGNOSIS
0832	3M GRP - RECORD DOES NOT MEET CRITERIA FOR ANY DRG
0833	3M GRP - INVALID AGE IN YEARS OR ADMISSION AGE IN DAY
0834	3M GRP - INVALID SEX
0835	3M GRP - INVALID DISCHARGE STATUS
0836	3M GRP - INVALID BIRTH WEIGHT
0837	3M GRP - INVALID DISCHARGE AGE IN DAYS
0838	3M GRP - INVALID PRINCIPAL DIAGNOSIS
0839	3M GRP - GESTATIONAL AGE/BIRTH WEIGHT CONFLICT
0850	BILLING DEADLINE EXCEEDED - DETAIL
0851	REBILL: ORIGINAL CLAIM DEADLINE EXCEEDED
0852	BILLING DEADLINE EXCEEDED - HEADER
0853	FINAL DEADLINE EXCEEDED - DETAIL
0854	TIMELY FILING - ORIGINAL ICN NOT FOUND
0855	FINAL DEADLINE EXCEEDED - HEADER
0856	DATE OF SERVICE EXCEEDS 36 MONTHS - DETAIL
0857	DATE OF SERVICE EXCEEDS 36 MONTHS - HEADER
0861	MEMBER MUST APPLY BEFORE ADMIN DAYS START
0862	EMERGENCY INDICATOR/POS MISMATCH
0870	INVALID START/STOP TIME
0871	VOID / ORIGINAL $ AMOUNT CONFLICT
0872	MONTH/YEAR MISMATCH ON ADJUSTMENT
0873	NDC SUBMITTED ON INVALID PROCEDURE
0874	PRESCRIPTION INVALID FOR COMPOUND DRUG
0875	PROCEDURE INVALID FOR COMPOUND DRUG
0876	INVALID PRODUCT QUALIFIER
0877	INVALID PRESCRIPTION QUALIFIER
0878	INVALID PRESCRIPTION QUALIFIER/ID COMBINATION
0879	INVALID PRESCRIPTION QUALIFIER/ID COMBINATION
0880	INVALID PRESCRIPTION ID

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EOB CODE	EOB DESCRIPTION
0881	INVALID PRESCRIPTION DATE
0882	PRESCRIPTION DATE GREATER THAN CLAIM DATE
0886	ATTACHMENT REQUIRED-PODIATRIC, SUSPEND FOR REVIEW
0888	DCN INVALID FOR ATTACHMENT CROSS-REFERENCE
0890	EDI TRANS TYPE IS 31
0891	EDI TRANS TYPE IS RP
0900	PROVIDER TYPE/SPEC GROUP EMPTY
0902	PROCEDURE CODE GROUP EMPTY
0903	OCCURRENCE CODE GROUP EMPTY
0904	VALUE CODE GROUP EMPTY
0905	REVENUE CODE GROUP EMPTY
0906	DIAGNOSIS GROUP EMPTY
0907	ICD-9 PROCEDURE GROUP EMPTY
0908	MODIFIER GROUP EMPTY
0909	PATIENT STATUS GROUP EMPTY
0910	BENEFIT PLAN GROUP EMPTY
0911	INTERNAL ERROR
0912	PROVIDER LOC GROUP EMPTY
0913	SPECIAL HANDLING GROUP EMPTY
0914	TYPE OF BILL GROUP EMPTY
0915	COUNTY CODE GROUP EMPTY
0916	ZIP CODE GROUP EMPTY
0917	PLACE OF SERVICE GROUP EMPTY
0918	MEMBER LOC GROUP EMPTY
0930	2ND OCCURRENCE POSITION NOT = 22
0931	2ND OCCURRENCE OCDE = 22 BUT AMOUNT = 0
0932	2ND OCCURRENCE AMOUNT > 0 BUT OSC NOT 22
0933	INP CLM BUT RATE ID NOT 71 OR ADM TYPE NE ELCTV[3]
0935	UB92 CLAIM BUT NO PATIENT ACCT NUMBER (MRN)
0937	DETAIL CANNOT SPAN DATES
0999	CLAIM SELECTED FOR MASSPRO EXTRACT
1000	BILLING PROVIDER I.D. NUMBER NOT ON FILE.
1001	COB-BENEFIT PLAN
1002	DTL PERFORMING PROVIDER NOT ELIGIBLE
1003	BILLING PROV NOT ELIG AT SERV LOC FOR PROG BILLED
1007	DETAIL RENDERING PROVIDER I.D. NOT ON FILE
1010	RENDERING PROVIDER NOT A MEMBER OF BILLING GROUP
1012	RENDERING PROV SPECLTY NOT ELIG TO RENDER PROCEDUR
1013	PROV ASSIGNMENT NOT ACCEPTED
1014	INVALID ASSIGNMENT INDICATOR
1018	PROVIDER RATE NOT ON FILE
1019	NO PROVIDER LEVEL OF CARE RATE ON FILE
1020	ATTENDING PHYSICIAN ID NOT ON FILE
1021	FIRST OTHER PHYSICIAN ID NOT ON FILE
1023	LEVEL OF CARE BILLED NOT ON FILE FOR THIS PROVIDER

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EOB CODE	EOB DESCRIPTION
1024	BILLING PROVIDER NOT LISTED AS MEMBER LTC PROV
1026	PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE
1027	HEADER REFERRING PHYSICIAN ID NOT ON FILE
1032	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLM TYP
1036	RENDERING PROVIDER NOT ELIGIBLE TO BILL THIS CLM TYPE
1037	FACILITY PROVIDER NUMBER NOT ON FILE
1046	NONBILLING PROV HAS NO-PAY, SUSPEND STATUS ACTION
1047	BILLING PROV HAS NO-PAY, SUSPEND STATUS ACTION
1048	NONBILLING PROV HAS NO-PAY STATUS ACTION
1049	BILLING PROV HAS NO-PAY STATUS ACTION
1050	SERVICE CANNOT BE REFERRED BY THE SAME BILLING PRO
1051	HEADER RENDERING PROVIDER ID NOT VALID
1053	DETAIL FIRST OTHER PHYSICIAN ID NUMBER NOT ON FILE
1054	DETAIL ATTENDING PHYSICIAN ID NUMBER NOT ON FILE
1055	DETAIL REFERRING PROV NOT ON FILE
1058	UNABLE TO CROSSWALK ATTENDING/OTHER1/OTHER2 MEDICARE PROVIDER ID
1060	UNABLE TO CROSSWALK RENDERING MEDICARE PROVIDER ID
1062	UNABLE TO CROSSWALK DETAIL RENDERING MEDICARE PROV
1063	UNABLE TO CROSSWALK BILLING MEDICARE PROVIDER ID
1064	HEADER REFERRING PROVIDER CANNOT BE SAME AS BILLIN
1065	DETAIL REFERRING PROVIDER CANNOT BE SAME AS BILLIN
1066	BILLING PROVIDER NOT A VALID BILLER
1067	RENDERING EQUALS BILLING AND NOT A VALID BILLER
1068	REFERRING PROVIDER REQUIRED FOR INDEPENDENT CERTIF
1069	REFERRING PROV CANNOT BE SAME AS RENDERING-HEADER
1070	REFERRING PROV CANNOT BE SAME AS RENDERING-DETAIL
1071	PATIENT STILL IN THE HOSPITAL
1073	BILLING PROVIDER OUT OF STATE CONTIGUOUS
1074	BILLING PROVIDER OUT OF STATE NON-CONTIGUOUS
1100	ADJUST: FORMER TCN INCORRECT
1101	INVALID ADJUSTMENT FORMER TCN
1104	REBILL : ORIGINAL CLAIM PAID
1108	THIS ADJUSTMENT CLAIM IS ALREADY ON HOLD
1111	ITEM/SERVICE(S) PROVIDED NOT MOST COST EFFECTIVE
1116	SHOE PRESCRIPTION FORM MISSING
1117	PROC REQ REPORT/ RPT MISSING
1119	BILLING RID CONFLICT
1120	CLAIM REQUIRES DOCUMENTATION (CAF EDIT)
1121	STERILIZATION FORM INCOMPLETE
1122	STERILIZATION REGS NOT MET
1123	CLAIM NOT LEGIBLE
1125	INCIDENTAL PROC NOT COVERED
1126	CHARGES NOT ITEMIZED
1127	HYSTERECTOMY REGS NOT MET
1130	INVALID STERILIZATION FORM

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EOB CODE	EOB DESCRIPTION
1132	CLAIMS REQ SPECIAL HANDLING
1134	UR LETTER NOT ACCEPTABLE
1135	CLAIM CONTAINS MEDICARE PART B COVERED CHARGES
1136	NOT AN ACCEPTABLE ATTACHMENT
1139	INVALID ABORTION FORM
1140	ABORTION FORM INCOMPLETE
1146	DUPE PREPAY REVIEW CLAIM OR RESUBMISSION ERROR
1149	PA# NOT ON FILE
1150	IDENT/DSCR PROC WHEN BILLING AN UNLISTED CODE
1151	COPAY EXEMPT - AGE
1152	ASST SURG NOT COV FOR PROC
1153	UR DENIED ADMISSION
1514	INCORRECT PROC CODE FOR SERVICE
1515	PROCEDURE CODE/ INVOICE CONFLICT (PHARM)
1516	INCORRECT REV CODE FOR SERV
1517	CLAIM MED NECESS FORM ERROR
1518	SERVICE PROVIDED REQUIRES A MORE DETAILED REPORT
1519	INAPPROPRIATE PROCEDURE CODE FOR SERVICE BILLED
1520	PAYMENT INCLUDED IN PRIMARY PROCEDURE
1521	PAYMENT MADE TO ANOTHER PHYSICIAN
1522	REPORT NOT LEGIBLE
1523	HYSTERECTOMY FORM INCOMPLETE
1524	INVALID HYSTERECTOMY FORM
1525	ABORTION REGS NOT MET
1526	MEDICAL RECORD NOT SUBMITTED TO PREPAYMENT REVIEW
1527	MED REC INCOMPLETE AS DETERMINED BY PREPAY REVIEW
1528	MLOA DAYS NOT INDICATED ON CLAIM FORM
1530	INVALID PRESCRIBING PROV TRANS
1662	BILLING PROVIDER I.D. NUMBER NOT 0N FILE
1801	NEED REFERRING PROVIDER FOR RADIOLOGY SERVICE
1802	MCARE PART B PRICED AT 0 FOR TOB 12X
1803	HOLD MCARE PART A CLAIMS WITH TOB 111 OR 114
1804	DENY CLAIM TYPE A WITH TOB 112 OR 113
1805	BILLING PROVIDER ID WAS TRANSLATED
1806	CROSSOVER PRICING PERFORMED - HEADER (PAY)
1807	CROSSOVER PRICING PERFORMED - DETAIL (PAY)
1808	UNABLE TO PERFORM CROSSOVER PRICING - HEADER (DENY)
1809	UNABLE TO PERFORM CROSSOVER PRICING - DETAIL (DENY)
1900	INVALID TAXONOMY CODE - BILLING PROVIDER
1901	INVALID TAXONOMY CODE-HEADER PERFORMING PROVIDER
1906	INVALID TAXONOMY FOR PROVIDER TYPE/SPEC - BILLING
1907	INVALID TAXONOMY FOR PROVIDER TYPE/SPEC - HEADER P
1912	TAXONOMY CODE MISSING - BILLING PROVIDER
1913	TAXONOMY CODE MISSING - HEADER PERFORMING PROVIDER
1919	INVALID TAXONOMY CODE - DETAIL PERFORMING PROVIDER

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EOB CODE	EOB DESCRIPTION
1921	INVALID TAXONOMY FOR PROVIDER TYPE/SPEC - DETAIL P
1925	TAXONOMY CODE MISSING - DETAIL PERFORMING PROVIDER
1927	NPI REQUIRED HEALTHCARE=Y BILLING PROV
1928	NPI REQUIRED HEALTHCARE=Y PERFORMING PROV
1929	NPI DEACTIVATION DUE TO FRAUD
1930	NPI DEACTIVATION DUE TO DEATH, DISBANDMENT, OR ORTHER
1934	DTL NPI REQUIRED HEALTHCARE=Y PERFORMING PROV
1936	INVALID BILLING PROVIDER SPECIFIED
1937	INVALID PERFORMING PROVIDER SPECIFIED
1943	INVALID DTL PERFORMING PROVIDER SPECIFIED
1945	MULT SAK PROV LOCS FOR BILLING PROV SPEC
1946	MULT SAK PROV LOCS FOR PERFORMING PROV SPEC
1949	MULT SAK PROV LOCS FOR RENDERING PROV SPEC
1950	NPI SUBMISSION ERROR
1952	MULT SAK PROV LOCS FOR DTL PERFORM PROV SPEC
1954	BILLING PROV ID NOT NPI BUT THERE IS NPI ON FILE
1960	BILLING PROVIDER ON REVIEW
1961	RENDERING PROVIDER ON REVIEW - HEADER
1962	RENDERING PROVIDER ON REVIEW - DETAIL
1995	RENDER/DISPENS/PERFORM PROV ID IN OLD FORMAT - HDR
1997	UNABLE TO POPULATE DTL PERFORMING PROV ID WITH HDR
1999	HEADER BILLING PROVIDER ID IN OLD FORMAT
2000	INVALID SEX
2001	MEMBER ID NUMBER NOT ON FILE
2002	MEMBER NOT ELIGIBLE FOR HEADER DATE OF SERVICE
2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE
2004	MULTIPLE AID CATEGORY CODES COVER HEADER SERVICE
2005	MULTIPLE AID CATEGORY CODES COVER DETAIL SERVICE
2006	CLAIMS SUBMITTED WITH LEGACY MEMBER ID
2007	QMB MEMBER- BILL MEDICARE FIRST
2008	MEMBER LEVEL OF CARE NOT ON FILE
2009	ERROR WITH HSN ELIGIBILITY WEB SERVICE
2011	PHARMCY MEDICAL/NON-MEDICAL SUPPL. AND ROUTINE DME
2014	MENTAL HLTH/SUBSTANCE ABUSE ONLY, BILL PARTNERSHIP
2017	MEMBER SERVICES COVERED BY MCO PLAN
2018	MEMBER IS INROLLED IN HOSPICE
2037	MEMBER ID IS INACTIVE
2041	MEMBER# ON CLAIM AND PA MISMATCH
2043	MEMBER IS ON REVIEW
2044	CLAIM INDICATES MEMBER EXPIRED
2049	LTC/HOSPICE CONFLICT
2051	MEMBER NOT CODED FOR LTC
2052	LEVEL OF CARE/AID CAT CONFLICT
2053	LTC/CASE MIX CONFLICT
2055	SUPPLEMENTAL ADULT SERVICE/LTC RECIPIENT CONFLICT

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EOB CODE	EOB DESCRIPTION
2056	MEMBER NOT CODED FOR CASEMIX
2057	DOS SPAN MONTHS-FILE SEPARATE CLAIMS FOR EACH MNTH
2500	MEMBER IS COVERED BY OTHER INSURANCE-PAY
2501	MEMBER IS COVERED BY OTHER INSURANCE - PAY AND
2502	MEMBER IS COVERED BY OTHER INSURANCE - DENY
2503	MEMBER IS COVERED BY OTHER INSURANCE - PAY & CHASE
2504	MEMBER IS COVERED BY OTHER INSURANCE - SUSPEND
2505	MEMBER COVERED BY MEDICARE-DENY
2509	MEMBER COVERED BY MEDICARE B (PHARMACY) - PROVIDER SHOULD BILL THROUGH POPS
2510	MEMBER MEDICAL SUPPORT BYPASS – DTL
2511	CANNOT DETERMINE TPL PRICING METHOD
2512	DUPLICATE CAS AT HEADER AND DETAIL
2513	TPL ADJUDICATION DATE NOT PRESENT- DETAIL
2514	TPL ADJUDICATION DATE NOT PRESENT-HEADER
2515	OTHER INSURER REQUIRES ADDITIONAL DATA
2516	MEDICAID IS ALWAYS FINAL PAYOR
2517	TPL REVIEW - CLM/EOB DIFFER
2518	OTHER PAYER HAS BUNDLED DETAILS
2519	CLAIM POTENTIALLY COVERED BY MEDICARE
2520	MEMBER IS COVERED BY OTHER INSURANCE-PAY,HEADER
2521	MEMBER IS COVERED BY OTHER INSURANCE - PAY AND REPORT
2522	MEMBER IS COVERED BY OTHER INSURANCE - DENY (HDR)
2523	MEMBER IS COVERED BY OTHER INSURANCE - PAY (CHASE)
2524	MEMBER IS COVERED BY OTHER INSURANCE - SUSPEND (HDR)
2525	MEMBER COVERED BY MEDICARE - DENY (HDR)
2526	ZERO TPL AMOUNT AND NO ADJ RSN CODE - HEADER
2527	ZERO TPL AMOUNT AND NO ADJ RSN CODE-DETAIL
2528	LTC - POTENTIAL MEDICARE IN FIRST 100 DAYS
2529	TPL AT HEADER AND NOT AT DETAIL
2530	INVALID TPL CARRIER CODE
2531	MCARE COVERAGE INDICATED ON CLAIM, NOT ON FILE
2532	HEBREW REHAB LTC TPL
2533	CARRIER IS 000 AND TPL AMOUNT > 0 - HEADER
2534	CARRIER IS 000 AND TPL AMOUNT > 0 -DETAIL
2535	INCORRECT TPL BILLING
2536	MCARE# ON CLAIM/FILE CONFLICT
2537	INVALID BUNDLED LINE NO ASSIGNED BY OTHER PAYER
2540	MEDICARE PAID > MEDICAID ALLOWED - HEADER
2541	MEDICARE PAID > MEDICAID ALLOWED - DETAIL
2543	MEDICARE PAYMENT OR PATIENT RESPONSIBILITY IS > 0
2544	BENEFITS EXHAUSTED REPRICING
2545	HEADER AND DETAIL COB PAYMENTS DO NOT BALANCE
2546	DETAIL COB PAYMENTS DO NOT BALANCE
2547	HEADER COB PAYMENTS DO NOT BALANCE
2548	NON COVERED AMT IS NOT EQUAL TO BILLED

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EOB CODE	EOB DESCRIPTION
2549	REMAINING PATIENT LIABILITY PRESENT AT HEADER
2550	REMAINING PATIENT LIABILITY PRESENT AT DETAIL
2551	CLAIM HAS NON-COVERED AMT, HDR IS NOT ELIGIBLE
2553	DETAIL ADJUSTMENT REASON CODE IS NOT ON ARC XREF
2555	INVALID FILING INDICATOR/CARRIER COMBINATION
2556	LTC - POTENTIAL MEDICARE C IN FIRST 100 DAYS
2557	LTC - POTENTIAL PRIVATE INSURANCE IN FIRST 100 DAYS
2558	OTHER PAYER DENIAL ARC IS NOT ON TABLE - HEADER
2559	OTHER PAYER DENIAL ARC IS NOT ON TABLE - DETAIL
2561	TPL DATA CONFLICT
2562	BENEFITS EXHAUSTED TPL REPRICING - DETAIL
2563	DETAIL ADJUSTMENT REASON CODE IS NOT ON ARC XREF
2564	MEMBER HAS MEDICARE SUPP INS DTL
2565	CLAIM REQUIRES TPL REVIEW
2566	MEMBER HAS MEDICARE SUPP INS
2567	INVALID SUBMITTER FOR COB CLAIM
2568	CLAIM HAS NON-COVERED AMT, DTL IS NOT ELIGIBLE
2569	MEMBER HAS SELF-REPORTED OTHER INSURANCE
2580	DETAIL, PROFESSIONAL OVERRIDE EDIT
2581	HEADER, INSTITUTIONAL OVERRIDE EDIT
2582	DETAIL, INSTITUTIONAL OVERRIDE EDIT
2583	NON COVERED AMT AND CAS PRESENT FOR PAYER
2584	MEMBER MEDICAL SUPPORT BYPASS - HDR
2585	EOB DATE AT HEADER AND DETAIL
2588	HEADER/COMMERCIAL/SUSPEND EDIT FROM THE TPL DENY T
2589	HEADER/MEDICARE/SUSPEND EDIT FROM THE TPL DENY TAB
2590	DETAIL/COMMERCIAL/PAY EDIT FROM THE TPL DENY TABLE
2591	DETAIL/MEDICARE/PAY EDIT FROM THE TPL DENY TABLE
2592	DETAIL/COMMERCIAL/DENY EDIT FROM THE TPL DENY TABLE
2593	DETAIL/MEDICARE/DENY EDIT FROM THE TPL DENY TABLE
2594	DETAIL/COMMERCIAL/SUSPEND EDIT FROM THE TPL DENY TABLE
2595	DETAIL/MEDICARE/SUSPEND EDIT FROM THE TPL DENY TABLE
2596	HEADER/COMMERCIAL/PAY EDIT FROM THE TPL DENY TABLE
2597	HEADER/MEDICARE/PAY EDIT FROM THE TPL DENY TABLE
2598	HEADER/COMMERCIAL/DENY EDIT FROM THE TPL DENY TABL
2599	HEADER/MEDICARE/DENY EDIT FROM THE TPL DENY TABLE
2608	MEMBER LOCKED-IN TO SPECIFIC NDC
2610	NON-COVERED DAYS > 0
2612	DMH OR DPH SUBCONTRACTOR NOT AUTHORIZED
2613	MANAGED CARE SERVICE
2614	MANAGED CARE SERVICE SHOULD BE PAID BY RMC
2615	SENIOR PHARMACY MUST BE BILLED THROUGH POPS
2616	SERV NOT REIMBURSABLE BY MED ASSISTANCE PROGRAM
2617	PROC CODE REQUIRES REVIEW OF REPORT
2620	REVENUE CODE REQ REVIEW

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EOB CODE	EOB DESCRIPTION
2621	BILL EXTENDED BENEFITS
2622	SERVICE NOT AUTHORIZED BY HMO
2623	PREPAYMENT TECHNICAL DENIAL
2625	MODIFIER INAPPROPRIATE/INCORRECT FOR SERV BILLED
2626	REQUEST FOR 90 DAY WAIVER DENIED
2627	SERVICE COVERED BY CASE MANAGER
2628	PREPAYMENT FULL DENIAL
2629	PREPAYMENT PARTIAL DENIAL
2630	NO PAS APPROVAL FOUND IN PREPAYMENT
2631	MCARE/BILL ALLOW PAID CONFLICT
2632	BENEFIT CONFLICT
2633	PREPAY PREVIOUSLY APPROVED
2634	PREPAY PREVIOUSLY DENIED
2635	PREPAY DECISION OVERTURNED
2640	NO RESPONSE TO OUR CAF
2800	MEMBER NOT TIED TO HOSPICE ON DOS
2802	NO BENEFIT PROGRAM FOR MEMBER FOUND
2803	PROCEDURE IS AGE RESTRICTED
2804	PROCEDURE IS INVALID FOR PATIENT SEX
2805	MULTIPLE PPA SEGMENTS ON MEMBER FILE
2900	SPAD CLAIM HAS CONTIGUOUS AID CATEGORY COVERAGE
3000	PER UNIT PRICE ON CLAIM DOES NOT MATCH PRIOR AUTH
3001	PA NOT FOUND ON DATABASE
3002	NDC REQUIRES PA
3003	PROCEDURE CODE REQUIRES PA
3004	INVALID PA/PASNUMBER
3005	INVALID PA/PAS NUMBER
3006	PA DOLLARS EXCEEDED
3009	PA/PAS NUMBER NOT ON THE DATABASE
3010	OUT OF STATE PROVIDER REQUIRES REVIEW
3013	PA NUMBER NOT ON THE DATABASE
3015	MODIFIER ON CLAIM AND PA MISMATCH
3022	SELECT FOR MASSPRO PRE-PAYMENT REVIEW
3023	INVALID RATE ID/PYMNT TYPE COMBINATION
3024	LINE ITEM NOT FOUND FOR PAS NUMBER
3025	MULTIPLE ACTIVE LINE ITEMS FOR PAS
3026	PAS NOT FOUND ON DATABASE
3027	INVALID PAS NUM
3028	NOT ENOUGH UNITS ON PAS
3029	MEMBER ID FOR CLAIM AND PAS DONT MATCH
3030	ADMISSION DATE FOR CLAIM AND PAS DONT MATCH
3031	PROVIDER ID FOR CLAIM AND PA/PAS DO NOT MATCH
3032	PAS IS REQUIRED
3033	PA/PAS IS NOT READY
3034	DUPLICATE CLAIM IN PRE-PAYMENT REVIEW

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EOB CODE	EOB DESCRIPTION
3035	CLAIM SELECTED FOR PRE-PAYMENT REVIEW
3036	RANDOM PRE-PAYMENT REVIEW PROCESS
3040	SURGERY/ASSIST USING SAME SERV PROVIDER NUMBER
3041	MEMBER# OR PROV# ON CLAIM AND PA MISMATCH
3101	PA STATUS IS VOID
3102	PA STATUS IS DENIED
3103	PROCEDURE NOT ON PA
3104	REVENUE CODE / PA CONFLICT
3105	MEMBER# ON CLAIM AND PA MISMATCH
3107	SERV DATE AFTER PA EXPIRED
3108	PA INSUFFICIENT AVAIL UNITS
3109	PA UNITS PRESENTLY EXHAUSTED
3110	PA EXHUSTED - CANNOT BE USED IN PRICING
3111	PRIOR AUTH PROCEDURE/MODIFIER MISMATCH
3120	REFERRAL REQUIRED ON CLAIM
3121	REFERRAL NUMBER INVALID
3122	NO MORE UNITS AVAILABLE ON REFERRAL
3124	RENDERING PROVIDER DOES NOT MATCH REFERRAL AUTH
3125	MEMBER IN CLAIM DOES NOT MATCH REFERRAL
3126	SERVICE DATE IS OUTSIDE REFERRAL AUTH
3300	JCODE GIVEN WITH INVALID NDC
3301	LTC CLAIM REQUIRES A PATIENT LIABILITY AMOUNT
3302	UNABLE TO DETERMINE RATE ID
3303	INVALID PROCEDURE/TOOTH SURFACE COMBINATION
3304	MANUFACTURERS INVOICE REQUIRED
3305	INVALID PATIENT PAY AMOUNT
3306	SPAD RATE NOT ALLOWED FOR TRANSFER PATIENT STATUS
3307	NO PATIENT LIABILITY ON FILE OR ON THE CLAIM
3310	CURRENT SUPPLIERS INVOICE REQUIRED
3311	ACQUISTION COST MISSING
3312	MAX FEE RELATIVE VALUE MUST BE > 0 ON DOS
3314	POS, MODIFIER INVALID FOR RADIOLOGY
3315	ICD9-CM STERILIZATION PROC REQUIRES ATTACHMENT
3316	ICD9-CM HYSTERECTOMY PROC REQUIRES ATTACHMENT
3317	ICD9-CM ABORTION PROC REQUIRES ATTACHMENT
3318	NON COVRD DAYS MUST BE NUMERIC FOR PROV TYPE 70/74
3319	PRIMARY DIAG CODE / AGE CONFLICT
3320	SECONDARY DIAG CODE / AGE CONFLICT
3321	3RD DIAG CODE / AGE CONFLICT
3322	4TH DIAG CODE / AGE CONFLICT
3323	5TH DIAG CODE / AGE CONFLICT
3324	6TH DIAG CODE / AGE CONFLICT
3325	7TH OR HIGHER DIAG CODE / AGE CONFLICT
3326	ADMITTING DIAG CODE / AGE CONFLICT
3327	TYPE OF BILL CANNOT BE CROSS WALKED TO A PLACE OF SERVICE

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EOB CODE	EOB DESCRIPTION
3335	NO VALID DERIVED RATE ID
3602	CLAIM AND EOB DIFFER
4001	BENEFIT PLAN BILL PR TYP RESTRICTION ON DIAGNOSIS
4002	NDC INDICATES A NON-COVERED DRUG ON DOS
4003	ATTACH REV ON ABORTION/STERIL/HYST DIAG
4004	NDC NOT ON FILE
4007	NON-COVERED NDC DUE TO CMS TERMINATION
4009	ALLOWED AMOUNT LESS THAN DRUG CHARGE VARIANCE
4010	MODIFIER REQUIRES MEDICAL REVIEW
4011	INVALID MODIFIER/MODIFIER COMBINATION
4012	ABORTION PROCEDURE INDICATED
4013	PROCEDURE CODE IS NOT COVERED FOR DATE OF SERVICE
4014	NO PRICING SEGMENT ON FILE
4015	MULTIPLE PRICING MODIFIERS ON CLAIM
4016	BENEFIT PLAN PERF PR TYP RESTRICTION ON DIAGNOSIS
4017	BENEFIT PLAN BILL PR TYP RESTRICTION ON DRG
4018	BENEFIT PLAN PERF PR TYP RESTRICTION ON DRG
4019	PROCEDURE CODE REQUIRES ATTACHMENT
4020	PROV CONTRACT UNIT RESTRICTION ON PROCEDURE
4021	PROCEDURE NOT COVERED FOR BENEFIT PLAN
4022	ABORTION DIAGNOSIS INDICATED
4023	GENDER IS NOT ALLOWED FOR COVERED NDC
4024	MAXIMUM NUMBER OF REFILLS HAS BEEN REACHED
4025	NDC VS. AGE RESTRICTION
4026	NDC VS. DAYS SUPPLY
4027	DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE
4028	BENEFIT PLAN GENDER RESTRICTION ON DIAGNOSIS
4029	BENEFIT PLAN POS RESTRICTION ON DIAGNOSIS
4030	BENEFIT PLAN AGE RESTRICTION ON DIAGNOSIS
4031	PROV CONTRACT GENDER RESTRICTION ON DIAGNOSIS
4032	PROCEDURE CODE NOT ON FILE
4033	INVALID PROC MOD COMBINATION
4034	BENEFIT PLAN AGE RESTRICTION ON PROCEDURE
4035	BENEFIT PLAN GENDER RESTRICTION ON PROCEDURE
4036	PROV CONTRACT POS RESTRICTION ON PROCEDURE
4037	PROCEDURE CODE VS. DIAGNOSIS RESTRICTION
4038	SERVICE NOT COVERED FOR LIMITED BENEFIT PLAN
4039	DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS
4040	PRIMARY DIAGNOSIS CODE NOT ON FILE
4041	SECONDARY DIAGNOSIS CODE NOT ON FILE
4042	THIRD DIAGNOSIS CODE NOT ON FILE OR INACTIVE
4043	FOURTH DIAGNOSIS CODE NOT ON FILE OR INACTIVE
4044	REIMBURSEMENT RULE AGE RESTRICTION
4045	REIMBURSEMENT RULE/BENEFIT PLAN RESTRICTION
4046	NO REIMBURSEMENT RULE FOR RATE ID

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EOB CODE	EOB DESCRIPTION
4047	FIFTH DIAGNOSIS CODE NOT ON FILE
4048	SIXTH DIAGNOSIS CODE NOT ON FILE
4049	SEVENTH DIAGNOSIS CODE NOT ON FILE
4050	EIGHTH DIAGNOSIS CODE NOT ON FILE
4051	NINTH DIAGNOSIS CODE NOT ON FILE
4052	TENTH DIAGNOSIS CODE NOT ON FILE
4053	PRINCIPAL PROCEDURE CODE NOT ON FILE
4054	FIRST OTHER PROCEDURE CODE NOT ON FILE
4055	SECOND OTHER PROCEDURE CODE NOT ON FILE
4056	THIRD OTHER PROCEDURE CODE NOT ON FILE
4057	FOURTH OTHER PROCEDURE CODE NOT ON FILE
4058	FIFTH OTHER PROCEDURE CODE NOT ON FILE
4059	REVENUE CODE NOT ON FILE
4060	ELEVENTH DIAGNOSIS CODE NOT ON FILE
4061	REIMBURSEMENT RULE CLAIM TYPE RESTRICTION
4062	REIMBURSEMENT RULE COND CODE RESTRICTION
4063	ICD-9-CM PROCEDURE CODE/AGE RESTRICTION
4064	BENEFIT PLAN GENDER RESTRICTION ON ICD9 PROC
4065	ICD9-CM PROCEDURE REQUIRES ATTACHMENT
4066	ICD9-CM PROCEDURE/DIAGNOSIS RESTRICTION
4067	NON-COVERED ICD-9-CM PROCEDURE CODE
4068	REIMBURSEMENT RULE/PROV CONTRACT RESTRICTION
4069	REIMBURSEMENT RULE RESTRICTION ON DIAGNOSIS ROLE
4070	REIMBURSEMENT RULE MODIFIER RESTRICTION
4071	REIMBURSEMENT RULE PAYER RESTRICTION
4072	REIMBURSEMENT RULE TAXONOMY RESTRICTION
4076	TWELFTH DIAGNOSIS CODE NOT ON FILE
4077	NON-COVERED REVENUE CODE
4085	INPATIENT PSYCH HOSP FOR MEMBERS AGE 22-64
4095	REIMBURSEMENT RULE UNIT RESTRICTION
4096	MODIFIER 99 NOT ALLOWED
4097	INVALID PROCESSING MODIFIER/RATE NOT FOUND
4098	FUND CODE FOR AID CAT/LOC NOT FOUND
4099	DRG NOT ON FILE
4113	UNIT DOSE PACKAGING COVERED FOR LTC RESIDENTS ONLY
4114	NO GPCI ON FILE
4115	NO RBRVS CONVERSION FACTOR
4117	ICD9 PROCEDURE IS NOT VALID FOR DATES OF SERVICE
4120	PROCEDURE CODE REQUIRES QUADRANT
4128	ICD9 PROCEDURE 7-24 NOT ON FILE
4132	DRG GROUPER UNABLE TO ASSIGN DRG
4135	APC GROUPER UNABLE TO GROUP/PRICE
4136	BENEFIT PLAN BILL PR TYP RESTRICTION ON ICD9 PROC
4137	BENEFIT PLAN PERF PR TYP RESTRICTION ON ICD9 PROC
4138	BILL PROV TYPE SPEC NOT VALID FOR COVERED-NDC

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MassHealth List of EOB Codes Appearing on the Remittance Advice

EOB CODE	EOB DESCRIPTION
4139	PERF PROV TYPE SPEC NOT VALID FOR COVERED-NDC
4140	BENEFIT PLAN BILL PR TYP RESTRICTION ON PROCEDURE
4141	BENEFIT PLAN PERF PR TYP RESTRICTION ON PROCEDURE
4142	BENEFIT PLAN BILL PR TYP RESTRICTION ON REVENUE
4143	BENEFIT PLAN PERF PR TYP RESTRICTION ON REVENUE
4144	PROV CONTRACT PERF PR TYP RESTRICTION ON DIAGNOSIS
4145	PROV CONTRACT BILL PR TYP RESTRICTION ON DRG
4146	PROV CONTRACT PERF PR TYP RESTRICTION ON DRG
4147	PROV CONTRACT PERF PR TYP RESTRICTION ON ICD9 PROC
4148	PERF PROV TYPE SPEC NOT VALID FOR CONTRACT-NDC
4149	PROV CONTRACT BILL PR TYP RESTRICTION ON PROCEDURE
4150	PROV CONTRACT PERF PR TYP RESTRICTION ON PROCEDURE
4151	PROV CONTRACT BILL PR TYP RESTRICTION ON REVENUE
4152	PROV CONTRACT PERF PR TYP RESTRICTION ON REVENUE
4153	PRIMARY NDC ON MEDICAL REVIEW FOR PROV. CONTRACT
4155	REIMBURSEMENT RULE POS RESTRICTION
4156	REIMBURSEMENT RULE PROV LOCAT RESTRICTION
4157	PROV CONTRACT/PROV CONTRACT RESTRICT ON DIAGNOSIS
4158	PROV CONTRACT/PROV CONTRACT RESTRICT ON DRG
4159	PROV CONTRACT/PROV CONTRACT RESTRICT ON ICD9 PROC
4160	PROVIDER CONTRACT RESTRICTION FOR CONTRACT NDC
4161	PROV CONTRACT/PROV CONTRACT RESTRICT ON PROCEDURE
4162	PROV CONTRACT/PROV CONTRACT RESTRICT ON REVENUE
4164	INACTIVE DRUG
4165	MAX DAY RESTRICTION FOR COVERED NDC
4166	REIMBURSEMENT RULE MEMB LOCAT RESTRICTION
4167	PROV CONTRACT UNIT RESTRICTION ON REVENUE
4168	BENEFIT PLAN UNIT RESTRICTION ON REVENUE
4170	UNITS BILLED GREATER THAN ALLOWED
4171	UNITS BILLED LESS THAN ALLOWED
4177	PROV CONTRACT BILL PR TYP RESTRICTION ON ICD9 PROC
4180	SECOND DIAG CODE NOT COVERED FOR DATE OF SERVICE
4181	THIRD DIAG CODE NOT COVERED FOR DATE OF SERVICE
4182	FOURTH DIAG CODE NOT COVERED FOR DATE OF SERVICE
4183	FIFTH DIAG CODE NOT COVERED FOR DATE OF SERVICE
4184	SIXTH DIAG CODE NOT COVERED FOR DATE OF SERVICE
4185	7 - 24 DIAG CODE NOT COVERED FOR DATE OF SERVICE
4186	ADMIT DIAG CODE NOT COVERED FOR DATE OF SERVICE
4187	EMERG DIAG CODE NOT COVERED FOR DATE OF SERVICE
4188	DIAGNOSIS CODE NOT COVERED FOR DATE OF SERVICE(DTL)
4189	SECOND DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)
4190	THIRD DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)
4191	FOURTH DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)
4192	FIFTH DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)
4193	SIXTH DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)

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MassHealth List of EOB Codes Appearing on the Remittance Advice

EOB CODE	EOB DESCRIPTION
4194	7 - 24 DIAG CODE NOT COVERED FOR DATE OF SERVICE(DTL)
4200	CLAIM PRICED AT ZERO
4203	MODIFIER IS NOT COVERED
4207	CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE
4208	INVALID CLIA CERTIFICATION/PROCEDURE CODE COMBINAT
4209	NO PRICING SEGMENT FOR PROCEDURE/MODIFIER COMBINAT
4210	MILEAGE RATE NOT ON FILE FOR DATE OF SERVICE
4211	TOOTH NUMBER/PROCEDURE CODE COMBINATION INVALID
4212	INVALID CLIA LAB CODE/PROC CODE/MODIFIER COMBINAT
4214	SERVICE DATE PRIOR TO CLIA CERTIFICATION DATE
4215	CLIA NUMBER TERMINATED
4222	NDC REQUIRES REVIEW
4223	BENEFIT PLAN REVIEW RESTRICTION ON PROCEDURE
4224	BENEFIT PLAN UNIT RESTRICTION ON PROCEDURE
4227	REVENUE NOT COVERED FOR BENEFIT PLAN
4229	BENEFIT PLAN REVIEW RESTRICTION ON DIAGNOSIS
4231	MAX UNIT RESTRICTION FOR BILLED NDC
4232	MAX DAY RESTRICTION FOR BILLED NDC
4233	DIAGNOSIS REQUIRES ADDITIONAL DOCUMENTATION
4235	IMPROPER MODIFIER FOR PROCEDURE BILLED
4236	INVALID USE OF E DIAGNOSIS CODE
4237	INVALID TYPE OF LEAVE FOR LTC CLAIM
4240	PROCEDURE MUST BE BILLED SEPARATELY FOR EACH DOS
4244	DIAGNOSIS NOT COVERED FOR BENEFIT PLAN
4245	FOURTH MODIFIER NOT COVERED
4246	ADJUSTMENT PAID AMOUNT EXCEEDS THE CASH RECEIPT BA
4248	MISSING MODIFIER FOR THIS PROCEDURE
4250	REIMBURSEMENT RULE PROV TYP RESTRICTION
4252	DX CODE 6-24 NOT ON FILE
4253	BENEFIT PLAN REVIEW RESTRICTION ON REVENUE
4254	BENEFIT PLAN AGE RESTRICTION ON REVENUE
4256	BENEFIT PLAN MODIFIER RESTRICTION ON PROCEDURE
4257	PROV CONTRACT MODIFIER RESTRICTION ON PROCEDURE
4258	SECONDARY DIAG RESTRICTION FOR BILLED NDC
4260	MEMBER NOT CODED FOR LTC
4261	MEMBER NOT CODED FOR CASEMIX
4310	PROV CONTRACT ADMIT DIAG RESTRICTION ON PROCEDURE
4311	PROV CONTRACT EMERG DIAG RESTRICTION ON PROC
4312	PROV CONTRACT PRIM DTL DIAG RESTRICT ON PROCEDURE
4313	PROV CONTRACT PRIM/SEC DTL DIAG RESTRICT ON PROC
4314	BENEFIT PLAN CLAIM TYPE RESTRICTION ON DIAGNOSIS
4315	PROV CONTRACT HDR DIAG RESTRICTION ON PROCEDURE
4316	PROV CONTRACT DTL DIAG RESTRICTION ON PROCEDURE
4317	PROV CONTRACT ADMIT DIAG RESTRICTION ON ICD9
4318	PROV CONTRACT DTL DIAG RESTRICTION ON ICD9

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EOB CODE	EOB DESCRIPTION
4319	PROV CONTRACT HDR DIAG RESTRICTION ON ICD9
4320	PROV CONTRACT ADMIT DIAG RESTRICTION ON REVENUE
4321	PROV CONTRACT DTL DIAG RESTRICTION ON REVENUE
4322	PROV CONTRACT PRIM/SEC DTL DIAG RESTRICT ON REV
4362	PROV CONTRACT TOB RESTRICTION ON DIAGNOSIS
4363	PROV CONTRACT TOB RESTRICTION ON DRG
4364	PROV CONTRACT TOB RESTRICTION ON ICD9 PROC
4365	PROV CONTRACT TOB RESTRICTION ON PROCEDURE
4371	BENEFIT PLAN CLAIM TYPE RESTRICTION ON PROCEDURE
4373	NDC COVERED BENEFIT CLAIM TYPE RESTRICTION
4374	BENEFIT PLAN CLAIM TYPE RESTRICTION ON REVENUE
4376	BENEFIT PLAN CLAIM TYPE RESTRICTION ON ICD9 PROC
4711	PROV CONTRACT AGE RESTRICTION ON DIAGNOSIS
4712	PROV CONTRACT AGE RESTRICTION ON DRG
4714	PROV CONTRACT AGE RESTRICTION ON ICD9 PROC
4715	PROV CONTRACT AGE RESTRICTION ON REVENUE
4716	AGE RESTRICTION FOR BILLED ICD9
4721	PROV CONTRACT PRIM/SEC DTL DIAG RESTRICTION ON DRG
4723	BENEFIT PLAN DTL DIAGNOSIS RESTRICTION ON ICD9
4724	BENEFIT PLAN PRIM/SEC DTL DIAG RESTRICTION ON ICD9
4726	BENEFIT PLAN ADMIT DIAG RESTRICTION ON ICD9
4730	REIMBURSEMENT RULE RESTRICTION ON DIAGNOSIS
4731	BENEFIT PLAN DTL DIAG RESTRICTION ON PROCEDURE
4732	BENEFIT PLAN ADMIT DIAG RESTRICTION ON REVENUE
4733	PROV CONTRACT ADMIT DIAG RESTRICTION ON DRG
4734	PROV CONTRACT DTL DIAGNOSIS RESTRICTION ON DRG
4736	BENEFIT PLAN DTL DIAG RESTRICTION ON REVENUE
4741	BENEFIT PLAN ADMIT DIAG RESTRICTION ON PROCEDURE
4742	BENEFIT PLAN EMERG DIAG RESTRICTION ON PROCEDURE
4743	BENEFIT PLAN PRIM/SEC DTL DIAG RESTRICT ON PROC
4744	BENEFIT PLAN PRIM/SEC DTL DIAG RESTRICTION ON REV
4745	BENEFIT PLAN HDR DIAG RESTRICTION ON PROCEDURE
4746	BENEFIT PLAN PRIM DTL DIAG RESTRICT ON PROCEDURE
4751	PROV CONTRACT TOB RESTRICTION ON REVENUE
4760	PROV CONTRACT REVIEW RESTRICTION ON ICD9 PROC
4762	PROV CONTRACT POS RESTRICTION ON ICD9 PROC
4765	ICD9 PROC NOT COVERED FOR BENEFIT PLAN
4766	BENEFIT PLAN AGE RESTRICTION ON ICD9 PROC
4767	BENEFIT PLAN POS RESTRICTION ON ICD9 PROC
4768	BENEFIT PLAN REVIEW RESTRICTION ON ICD9 PROC
4776	PROV CONTRACT BILL PR TYP RESTRICTION ON DIAGNOSIS
4801	PROCEDURE NOT COVERED BY PROVIDER CONTRACT
4802	DIAGNOSIS NOT COVERED BY PROVIDER CONTRACT
4804	REVENUE NOT COVERED BY PROVIDER CONTRACT
4805	DRG NOT COVERED BY PROVIDER CONTRACT

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EOB CODE	EOB DESCRIPTION
4806	ICD9 PROC NOT COVERED BY PROVIDER CONTRACT
4812	PROV CONTRACT REVIEW RESTRICTION ON DIAGNOSIS
4813	PROV CONTRACT REVIEW RESTRICTION ON PROCEDURE
4814	PROV CONTRACT REVIEW RESTRICTION ON REVENUE
4821	BENEFIT PLAN POS RESTRICTION ON PROCEDURE
4822	PROV CONTRACT POS RESTRICTION ON DIAGNOSIS
4825	MIXED HOLIDAY/WEEKEND/WEEKDAY DATES
4831	NO REIMBURSEMENT RULE FOR SERVICE
4845	PROV CONTRACT REVIEW RESTRICTION ON DRG
4863	NDC COVERED FOR A PORTION OF THE DOS
4866	BENEFIT PLAN POS RESTRICTION ON REVENUE
4867	PROV CONTRACT POS RESTRICTION ON REVENUE
4871	PROV CONTRACT CLAIM TYPE RESTRICTION ON PROCEDURE
4872	PROV CONTRACT CLAIM TYPE RESTRICTION ON DIAGNOSIS
4874	PROV CONTRACT CLAIM TYPE RESTRICTION ON REVENUE
4875	PROV CONTRACT CLAIM TYPE RESTRICTION ON DRG
4876	PROV CONTRACT CLAIM TYPE RESTRICTION ON ICD9 PROC
4881	PROV CONTRACT POS RESTRICTION ON DRG
4882	DRG NOT COVERED FOR BENEFIT PLAN
4883	BENEFIT PLAN REVIEW RESTRICTION ON DRG
4884	BENEFIT PLAN AGE RESTRICTION ON DRG
4886	BENEFIT PLAN CLAIM TYPE RESTRICTION ON DRG
4887	BENEFIT PLAN POS RESTRICTION ON DRG
4900	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON DIAGNOSIS
4901	BENEFIT PLAN COND CODE RESTRICTION ON DIAGNOSIS
4902	BENEFIT PLAN OCCUR CODE RESTRICTION ON DIAGNOSIS
4903	BENEFIT PLAN RESTRICTION ON DIAGNOSIS ROLE
4910	PROV CONTRACT/BENEFIT PLAN RESTRICT ON DIAGNOSIS
4911	PROV CONTRACT COND CODE RESTRICTION ON DIAGNOSIS
4912	PROV CONTRACT OCCUR CODE RESTRICTION ON DIAGNOSIS
4913	PROV CONTRACT RESTRICTION ON DIAGNOSIS ROLE
4914	PROV CONTRACT OCCUR CODE RESTRICTION ON DRG
4920	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON DRG
4921	BENEFIT PLAN COND CODE RESTRICTION ON DRG
4922	BENEFIT PLAN OCCUR CODE RESTRICTION ON DRG
4930	BENEFIT PLAN RESTRICTION FOR CONTRACT DRG
4931	PROV CONTRACT COND CODE RESTRICTION ON DRG
4935	BENEFIT PLAN GENDER RESTRICTION ON DRG
4936	PROV CONTRACT GENDER RESTRICTION ON DRG
4940	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON ICD9 PROC
4941	BENEFIT PLAN COND CODE RESTRICTION ON ICD9 PROC
4942	BENEFIT PLAN OCCUR CODE RESTRICTION ON ICD9 PROC
4944	PROV CONTRACT GENDER RESTRICTION ON ICD9 PROC
4950	PROV CONTRACT/BENEFIT PLAN RESTRICT ON ICD9 PROC
4951	PROV CONTRACT COND CODE RESTRICTION ON ICD9 PROC

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EOB CODE	EOB DESCRIPTION
4952	PROV CONTRACT OCCUR CODE RESTRICTION ON ICD9 PROC
4963	PROV CONTRACT GENDER RESTRICTION ON PROCEDURE
4964	PROV CONTRACT GENDER RESTRICTION ON REVENUE
4967	BENEFIT PLAN GENDER RESTRICTION ON REVENUE
4970	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON REVENUE
4971	BENEFIT PLAN COND CODE RESTRICTION ON REVENUE
4972	BENEFIT PLAN OCCUR CODE RESTRICTION ON REVENUE
4975	PROV CONTRACT/BENEFIT PLAN RESTRICT ON REVENUE
4976	PROV CONTRACT COND CODE RESTRICTION ON REVENUE
4977	PROV CONTRACT OCCUR CODE RESTRICTION ON REVENUE
4980	BENEFIT PLAN/BENEFIT PLAN RESTRICTION ON PROCEDURE
4981	BENEFIT PLAN COND CODE RESTRICTION ON PROCEDURE
4982	BENEFIT PLAN OCCUR CODE RESTRICTION ON PROCEDURE
4990	PROV CONTRACT/BENEFIT PLAN RESTRICT ON PROCEDURE
4991	PROV CONTRACT COND CODE RESTRICTION ON PROCEDURE
4992	PROV CONTRACT OCCUR CODE RESTRICTION ON PROCEDURE
4999	THIS DRUG NOT COVERED BY MEDICARE PART D
5000	EXACT DUPLICATE - INPATIENT CLAIM
5001	SUSPECT DUPLICATE - INPATIENT CLAIM- DIFFERENT PROVIDER
5002	CONFLICT - INPATIENT VS OUTPATIENT
5003	CONFLICT - INPATIENT VS LONG TERM CARE
5004	EXACT DUPLICATE-INPATIENT/LTC/HOMEHEALTH CROSSOVER
5005	SUSPECT DUPLICATE-INPATIENT/LTC/HOMEHEALTH CROSSOV
5006	EXACT DUPLICATE - PHYSICIAN CROSSOVER
5007	SUSPECT DUPLICATE - PHYSICIAN CROSSOVER- DIFFERENT PROVIDER
5008	CONFLICT- PHYSICIAN VS CROSSOVER B
5009	CONFLICT-LONG TERM CARE VS CROSSOVER A
5010	EXACT DUPLICATE-OUTPATIENT CLAIM
5011	SUSPECT DUPLICATE-OUTPATIENT CLAIM-DIFFERENT PROVIDER
5012	EXACT DUPLICATE-OUTPATIENT CROSSOVER
5013	SUSPECT DUPLICATE-OUTPATIENT CROSSOVER DIFFERENT PROVIDER
5014	EXACT DUPLICATE-OUTPATIENT LAB SERVICES
5015	SUSPECT DUPLICATE OUTPATIENT LAB SERVICES DIFFERENT PROVIDER
5016	EXACT DUPLICATE OUTPATIENT RADIOLOGICAL SERVICES
5017	SUSPECT DUPLICATE-OUTPATIENT RADIOLOGY SERVICES
5018	SUSPECT DUPLICATE OUTPATIENT SURGICAL SERVICES (OPERATION ROOM / AMB SURG CTR)
5019	SUSPECT DUPLICATE OUTPATIENT SERGICAL SERVICES (OPER ROOM/AMB SWG CTR)-DIFFEREN
5020	SUSPECT DUPLICATE OUTPATIENT PROCEDURE
5021	SUSPECT DUPLICATE OUTPATIENT PROCEDURE(OPER ROOM/AMB SURG CTR) DIFFERENT PROVID
5022	SUSPECT DUPLICATE OUTPATIENT PROCEDURES (OPER ROOM/ AMB SURG CTR)
5023	SUSPECT DUPLICATE OUTPATIENT PROCEDURE (OPER ROOM/ AMB SURG CTR) DIFFERENT PROV
5024	SUSPECT DUPLICATE OUTPATIENT SERGICAL SERVICES
5025	SUSPECT DUPLICATE OUTPATIENT SERGICAL SERVICES (EMERG ROOM/ CLINIC) DIFFERENT P
5026	SUSPECT DUPLICATE OUTPATIENT SERGICAL SERVICES EMERGENCY ROOM/ CLINIC
5027	SUSPECT DUPLICATE OUTPATIENT SURGICAL SERVICES- EMERG ROOM/CLINIC- DIFFERENT PR

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EOB CODE	EOB DESCRIPTION
5028	OPD EXACT DUP CRITERIA=E- CLAIM TYPE O-UB04 INV 03
5029	OPD SUSPECT DUP CRITERIA=E-CLAIM TYPE O -UB4 INV 3
5030	XACT DUPLICATE OUTPATIENT PROCEDURES (OPER ROOM/AMB SURG CTR/EMERG ROOM/CLINIC)
5031	SUSPECT DUPLICATE OUTPATIENT PROCEDURE (OR/AMB SURG CTR/ER/CLINIC) -DIFFERENT P
5032	EXACT DUPLICATE-OUTPATIENT PROCEDURES (OPER ROOM / EMERG ROOM/ CLINIC)
5033	SUSPECT DUPLICATE OUTPATIENT PROCEDURES- DIFFERENT PROVIDER
5034	OPD EXACT DUP CRITERIA=E1-CLAIM TYPE O-UB04 INV 03
5035	OPD SUSPECT DUP CRITERIA=E1-CLAIM TYP O -UB4 INV 3
5036	OPD EXACT DUP CRITERIA=F- CLAIM TYPE O-UB04 INV 03
5037	OPD SUSPECT DUP CRITERIA=F- CLAIM TYP O -UB4 INV 3
5038	OPD EXACT DUP CRITERIA=F1-CLAIM TYPE O-UB04 INV 03
5039	OPD SUSPECT DUP CRITERIA=F1-CLAIM TYP O -UB4 INV 3
5040	OPD EXACT DUP CRITERIA=G-CLAIM TYPE O-UB04 INV 03
5041	OPD SUSPECT DUP CRITERIA=G -CLAIM TYP O -UB4 INV 3
5042	OPD EXACT DUP CRITERIA=H-CLAIM TYPE O-UB04 INV 03
5043	OPD SUSPECT DUP CRITERIA=H -CLAIM TYP O -UB4 INV 3
5044	EXACT DUPLICATE - PHYSICAN CLAIM
5045	SUSPECT DUPLICATE-PHYSICIAN CLAIM- DIFFERENT PROVIDER
5046	EXACT DUPLICATE OUTPATIENT PROCEDURES (CLINIC)
5047	SUSPECT DUPLICATE OUTPATIENT PROCEDURES (CLINIC)
5048	SUSPECT DUPLICATE OUTPATIENT PROCEDURES (CLINIC)
5049	SUSPECT DUPLICATE OUTPATIENT PROCEDURE (CLINIC)
5050	EXACT DUPLICATE HOME HEALTH CLAIM
5051	SUSPECT DUPLICATE- HOME HEALTH -DIFFERENT PROVIDER
5052	EXACT DUPLICATE - LONG TERM CARE
5053	SUSPECT DUPLICATE-LONG TERM CARE-DIFFERENT PROVIDER
5054	OPD EXACT DUP CRITERIA=M-CLAIM TYPE O-UB04 INV 03
5055	OPD SUSPECT DUP CRITERIA=M-CLAIM TYP O -UB4 INV 3
5056	DUPLICATE SERVICE (DENTAL ONLY)
5057	DUPLICATE SERVICE (PHARMACY ONLY)
5058	OPD EXACT DUP CRITERIA=M1-CLAIM TYPE O-UB04 INV 03
5059	OPD SUSPECT DUP CRITERIA=M1-CLAIM TYP O -UB4 INV 3
5060	OPD EXACT DUP CRITERIA=N-CLAIM TYPE O-UB04 INV 03
5061	OPD SUSPECT DUP CRITERIA=N-CLAIM TYP O -UB04 INV 3
5062	EXACT DUPLICATE OUTPATIENT PROCEDURES (TREATMENT ROOM)
5063	SUSPECT DUPLICATE OUTPATIENT PROCEDURES (TREATMENT ROOM)
5064	CONFLICT: INPATIENT VS. CROSSOVER A
5065	CONFLICT: HOME HEALTH VS. OUTPATIENT
5066	CONFLICT: HOME VS. PHYSICIAN
5067	CONFLICT: HOME VS. CROSSOVER B
5068	CONFLICT: HOME HEALTH VS. CROSSOVER A
5069	CONFLICT: HOME HEALTH VS. CROSSOVER C
5070	CONFLICT: OUTPATIENT VS. CROSSOVER C
5071	PA IS REQUIRED FOR BASIC MEMBERS
5072	CONFLICT: LTC VS. PROV TYPE 58 59 62 63 64 66 68

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EOB CODE	EOB DESCRIPTION
5073	CONFLICT: HOSPICE VS. LONG TERM CARE
5080	SURG/ASSIST SURG SAME DOS SAME PROVIDER
5081	TEMP AUDIT 5081
5082	ONE PRIMARY SURGERY PER DAY
5083	LIMIT 1 SURGICAL CODE WITH DIFFERENT MOD PER DAY
5084	ASST SURGERY BILATERAL LIMIT MOD 80
5085	ONE PRIMARY ASSIST SURGERY PER DAY
5086	ASST SURGERY BILATERAL LIMIT MOD 82
5087	ASST SURGERY BILATERAL LIMIT MOD 81
5091	DIFFERENT PROVIDER FROM SAME GROUP NOT ALLOWED
5096	NCCI CONFLICT WITH ADJUSTED OTH SERV PREV PAID
5200	PAPE SERVICES SHOULD BE ON SINGLE CLAIM
5210	ATP SERVICES SHOULD BE ON SINGLE CLAIM
5927	NCCI - ANOTHER SERVICE PREV PAID – SAME CLAIM
5928	NCCI – ANOTHER SERVICE PREV PAID – OTHER CLAIM
5929	NCCI – CONFLICT WITH OTHER SERVICE PREV PAID
5930	MUE UNITS EXCEEDED
5935	LABORATORY PANELS DENIED
6000	MANUAL PRICING REQUIRED
6001	MANUAL PRICING NOT ALLOWED ON ADJUSTMENT
6002	INVALID UNIT CODE FOR ANESTHESIA
6003	PAID AMOUNT IS LESS THAN MINIMUM THRESHOLD - HDR
6004	PAID AMOUNT EXCEEDS THRESHOLD - DTL
6005	COPAY REVIEW AMOUNT WAS REACHED
6007	PAID AMOUNT LESS THAN MINIMUM THRESHOLD - DTL
6008	AMOUNT EXCEEDS MAXIMUM THRESHOLD - DTL
6018	EXCESSIVE MLOA DAYS TAKEN
6019	EXCESSIVE MLOA DAYS TAKEN
6020	MLOA DAYS EXCEEDS MAX
6021	ATP ELIGIBLE CODE
6022	ATP BUNDLED CLAIM
6023	ATP PROCEDURE NOT ON MAX FEE TABLE (PROFESSIONAL)
6024	ATP PROCEDURE NOT ON MAX FEE TABLE (OUTPATIENT)
6025	ATP PROCEDURE NOT ON ATP CODE TABLE (PROFESSIONAL)
6026	ATP PROCEDURE NOT ON ATP CODE TABLE (OUTPATIENT)
6027	NO TPL PRICING METHOD FOUND FOR ATP PRICING FOR PROFESSIONAL CLAIM
6028	NO TPL PRICING METHOD FOUND FOR ATP PRICING FOR OUTPATIENT CLAIM
6030	PROVIDER PRICING METHOD NOT FOUND (OUTPATIENT)
6031	PAPE ELIGIBLE PROCEDURE
6032	SYSTEM GENERATED CLAIM PAYING PAPE PRICE
6040	NMLOA AUDIT
6041	NMLOA AUDIT
6125	RETURN MONEY VOID / MATCHED CLM ADJUSTED OR VOIDED
6126	MODIFIER MANUALLY PRICED
6140	CLAIM WAS MANUALLY PRICED

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EOB CODE	EOB DESCRIPTION
6760	CLAIM SUSPENDED FOR ATTACHMENT REVIEW
6761	DCN IS INVALID AND ATTACHMENT REQUIRED FOR SERVICE
6762	ATTACHMENT MISSING FOR PODIATRIC SERVICES
7751	DENIED AFTER REVIEW OF NCCI/MUE REQUEST
7752	INSUFFICIENT INFORMATION FOR NCCI/MUE REQUEST
7753	DUPLICATE NCCI/MUE REQUEST
7754	SERVICES/CHARGES RELATED TO THE TREATMENT OF A HOSPITAL-ACQUIRED CONDITION OR PREVENTABLE MEDICAL ERROR
8000	1 CASE CONSULT IN 3 MONTHS = 2 UNITS
8001	LIMIT 1 PROC CODE PER MEMBER PER DAY-VARIOUS CODES
8002	ESRD RELATED SERVICES 1 PER MONTH
8003	PA IS REQUIRED FOR BASIC MEMBERS
8004	MODIFIER 26 REQUIRED IN HOSPITAL SETTING
8005	CONTRACEPTIVE INJECTABLE 3MTH. DEPRO-PROVERA
8006	CONTRACEPTIVE INJECTABLE LUNELLE 1 PER MONTH
8007	T1028, 1 ASSESSMENT = 3 COMPONENTS/UNITS PER YEAR
8008	T1024, 3 TEAM MEETINGS = 9 UNITS/COMPONENTS PER YR
8009	1 ASSIST AT SURGERY/PER MEMB/PER DAY
8010	LIMIT 1 ANESTHESIA CODE PER MEMBER PER DAY
8011	2 MONURAL CODE V5241 DISPENSING FEES IN 5 YEARS
8012	8 VISITS 99402 ALLOWED FOR CHC/FP PER YEAR
8013	2 REEVALUATIONS (99456-TS) PER YEAR
8014	PHARMACY CODES - MAX 31 UNITS PER MONTH
8015	ORTHOTICS - 1 UNIT IN 1 YEAR FROM DOS
8016	ORTHOTICS 2 UNITS IN 1 YEAR FROM DOS
8017	ORTHOTICS 4 UNITS IN 1 YEAR FROM DOS
8018	ORTHOTICS 3 UNITS IN 6 MONTHS
8019	ORTHOTICS 6 UNITS IN 1 YEAR
8020	ORTHOTICS 8 UNITS IN 1 YEAR
8021	ORTHOTIC 1 UNIT IN 3 YEARS
8022	PROSTHETICS 12 UNITS IN 1 YEAR
8023	2 STOCKINGS IN 7 MONTHS
8024	1 LITHIUM ION BATTERY CHARGER IN 2 YEARS
8025	HOME HEALTH PT LIM 20 VIS (120 UNITS) 12 MONTHS
8026	HOME HEALTH OT LIM 20 VIS (120 UNITS) 12 MONTHS
8027	HOME HEALTH ST LIM 35 VIS (140 UNITS)12 MONTHS
8028	DME 1 UNIT IN 1 CALENDAR MONTH
8029	DME 2 UNITS IN 1 CALENDAR MONTH
8030	DME 3 UNITS IN 1 CALENDAR MONTH
8031	DME 4 UNITS IN 1 CALENDAR MONTH
8032	DME 10 UNITS IN 1 CALENDAR MONTH
8033	DME LIMIT 6 UNITS IN 1 MONTH
8034	DME 12 UNITS IN 1 CALENDAR MONTH
8035	DME 18 UNITS IN 1 CALENDAR MONTH
8036	DME LIMIT 20 UNITS IN 1 CALENDAR MONTH

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EOB CODE	EOB DESCRIPTION
8037	DME LIMIT 30 UNITS IN 1 CALENDAR MONTH
8038	DME LIMIT 31 UNITS IN 1 CALENDAR MONTH
8039	DME LIMIT 35 UNITS IN 1 CALENDAR MONTH
8040	DME LIMIT 40 UNITS IN 1 CALENDAR MONTH
8041	DME LIMIT 60 UNITS IN 1 CALENDAR MONTH
8042	DME LIMIT 93 UNITS IN 1 CALENDAR MONTH
8043	DME LIMIT 100 UNITS IN 1 CALENDAR MONTH
8044	DME LIMIT 120 UNITS IN 1 CALENDAR MONTH
8045	DME LIMIT 250 UNITS IN 1 CALENDAR MONTH
8046	DME LIMIT 720 UNITS IN 1 CALENDAR MONTH
8047	DME LIMIT 1000 UNITS IN 1 CALENDAR MONTH
8048	DME LIMIT 1 UNIT IN 3 CALENDAR MONTHS
8049	DME LIMIT 2 UNIT IN 3 CALENDAR MONTHS
8050	DME LIMIT 3 UNITS IN 3 MONTHS MOD=KS ONLY
8051	DME LIMIT 4 UNITS IN 3 CALENDAR MONTHS
8052	DME LIMIT 5 UNITS IN 3 MTHS MODIFR KS ONLY
8053	DME LIMIT 6 UNITS IN 3 MONTHS
8054	DME LIMIT 15 UNITS IN 3 MTHS MOD KX ONLY
8055	DME LIMIT 8 UNITS IN 3 MTHS MOD KX ONLY
8056	DME LIMIT 9 UNITS IN 3 CALENDAR MTHS
8057	DME LIMIT 10 UNITS IN 6 MONTHS
8058	DME LIMIT 1 UNIT IN 6 MONTHS
8059	DME LIMIT 2 UNITS IN 6 MONTHS
8060	DME LIMIT 16 UNITS IN 6 MONTHS
8061	DME LIMIT 1 UNIT IN 12 MONTHS
8062	DME LIMIT 2 UNITS IN 12 MONTHS
8063	DME LIMIT 4 UNITS IN 12 MONTHS
8064	DME LIMIT 8 UNITS IN 12 MONTHS
8065	DME LIMIT 12 UNITS IN 12 MONTHS
8066	DME LIMIT 1 UNIT IN 24 MONTHS
8067	DME LIMIT 1 UNIT IN 3 YEARS
8068	DME LIMIT 2 UNITS IN 3 YEARS
8069	DME LIMIT 1 UNIT IN 5 YEARS
8070	LIMIT 27 UNITS PER MONTH
8071	DME LIMIT 36 UNITS PER MONTH
8072	DME LIMIT 12 PER MNTH PER WOUND=108 UNITS
8073	DME LIMIT 30 PER MTH PER WOUND=27O UNITS
8074	DME LIMIT 31 PER MTH PER WOUND=279 UNITS
8075	DME LIMIT 45 PER MTH PER WOUND=405 UNITS
8076	DME LIMIT 60 PER MTH PER WOUND=540 UNITS
8077	DME LIMIT 80 PER MTH PER WOUND=720 UNITS
8078	DME LIMIT 100 PER MTH PER WOUND=900 UNITS
8079	DME LIMIT 160 PER MTH PER WOUND=1440 UNITS
8080	DME LIMIT 200 PER MTH PER WOUND=1800 UNITS
8081	DME LIMIT 240 PER MTH PER WOUND=2160 UNITS

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EOB CODE	EOB DESCRIPTION
8082	DME LIMIT 100 PER WOUND IN 3 MTHS =900 UNITS
8083	DME LIMIT 11 UNITS PER MONTH
8084	DME LIMIT 150 UNITS PER MONTH
8085	DME LIMIT 124 UNITS PER MONTH
8086	DME LIMIT 15 UNITS PER MONTH
8087	DME LIMIT 90 UNITS PER MONTH
8088	SCREENING/INTAKE 8 UNITS T1023 PER MBR PER 12 MTHS
8089	DAY HABILITATION LIMIT 1 PER DAY EXCEPT MOD-22
8090	PA REQUIRED FOR MOBILITY REPAIR OVER $1,000
8100	TOOTH PREVIOUSLY EXTRACTED
8102	DME SURGICAL CODES REQUIRE ONE OF THE A1 THROUGH A9 MODIFIERS.
8104	DIABETIC SUPPLIES/INFUSION SUPPLIES REQR MODIFIER
8112	LIMIT 10 UNITS PER DAY PROC 80100
8113	LIMIT 13 UNITS PER DAY PROC 80101
8114	LIMIT 1 UNIT PER DAY - VARIOUS CODES
8115	TEMP AUDIT 8115
8116	LIMIT 4 UNITS PER DAY PROC 80102
8117	TEMP AUDIT 8117
8118	LIMIT 1 CESAREAN PER DAY (SURG)
8119	TEMP AUDIT 8119
8120	LIMIT 1 LAPAROSCOPIC CHOLECYSTECTOMY PER DAY(SURG)
8150	NEW AND DELETED CODES CANNOT BE BILLED ON THE SAME DAY
8156	MODIFIER REQUIRED FOR CODE 96110-NOT PRESENT
8175	SERVICE PROVIDED ON THE SAME DAY OF A GLOBAL SURGICAL PROCEDURE IS INCLUDED IN FEE AMT
8176	SERVICE PROVIDED ON THE DAY OF & DURING 10 DAY GLOBAL SURGICAL PROCEDURE INCLUDED
8177	SERVICE PROVIDED DAY BEFORE & DURING 90 DAY GLOBAL SURGICAL PROCEDURE INCLUDED
8185	MASS ADJUSTMENT - RETROACTIVE RATE CHANGE.
8242	ATP/PAPE ADJUSTMENT/VOID EOB
8250	INVALID COMBINATION OF PROCEDURES
8251	SPEECH THERAPY LIMIT 35 VISITS IN 12 MONTHS
8252	INVALID COMBINATION OF PROCEDURES
8253	VISIT & SURGERY NOT ALLOWED SAME DAY/SAME POS
8254	MULTIPLE VISITS NOT ALLOWED SAME DAY
8255	CHIROPRACTOR MANIPULATION / VISIT = 1 PER DAY
8256	CHIROPRACTOR MANIPULATION / VISIT 20 PER YEAR
8257	CONFLICT ACUPUNCTURE WITH METHADONE ADMINIST
8258	MONTHLY ESRD CONFLICTS WITH DAILY ESRD
8259	MONTHLY ESRD 1 PER MONTH
8260	1 LEVEL OF MUNICIPAL MEDICAID STUDENT/DAY
8261	10 HOURS PDN PER DAY FOR 22 SCHOOL DAYS
8262	MUNI MEDICAID PROCS CONFLICT WITH THERAPY
8263	LAB UNRINALYSIS CONFLICT W/ EACH OTHER ON SAME DAY
8264	OTHER LAB TESTS CONF W/GENERAL HEALTH LAB TESTS
8265	OTHER LAB TESTS CONFLICT W/ OBSTETRIC PANEL
8266	LIPID PANEL CONFLICTS WITH OTHER LAB TESTS

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EOB CODE	EOB DESCRIPTION
8267	LAB HEMATOLOGY CONFLICT W/EACH OTHER ON SAME DOS
8268	PHYSICAL THERAPY CODES LIMIT 1 HR (4 UNITS) PER DY
8269	OCCUPATIONAL THERAPY LIMIT 1 HR (4 UNITS) PER DAY
8270	SPEECH THERAPY CODES LIMIT 1 HR (4 UNITS) PER DAY
8271	ANTEPARTUM CARE LIMIT 1 OF EITHER CODE PER YEAR
8272	AMBULANCE ALS CONFLICTS WITH BLS SAME DAY
8273	2 PAIRS SHOES DURING 12 MONTH PERIOD
8274	2 MONAURAL HEARING AIDS IN 5 YEARS
8275	1 BINAURAL HEARING AID IN 5 YEARS
8276	1 DISPENSING FEE IN 5 YRS (BILATERAL)
8277	EVAL & MANGMNT CONFLICTS W/TREATMENT PROC SAME DAY
8278	DELIVERY CONFLICTS WITH FETAL STRESS TEST
8279	1 NEW PATIENT VISIT WITHIN 3 YEARS
8280	CONSULTATION CONFLICTS W/ REFRACTION
8281	DIAPERS LIMIT 248 PER MEMB/PER CAL MONTH
8282	4 STOCKINGS IN 6 MONTHS PER MEMBER
8283	OUTPATIENT HOSP SPEECH THERAPY LIMIT 35 VIS 12 MTH
8284	OUTPATIENT HOSP PHYSICAL THERAPY LIM 20 VIS/12 MTH
8285	OUTPATIENT HOSP OCCUPTNL THERAPY LIM 20 VIS/12 MTH
8286	PHYSICIAN PHYSICAL THERAPY LIMIT 20 VISITS/12 MTH
8287	PHYSICIAN OCCUPATIONAL THERAPY LIMIT 20 VIS/12 MTH
8288	PHYSICIAN SPEECH THERAPY LIMIT 35 VISITS/12 MTHS
8289	SPEECH AND HEARING CENTER SPEECH THERAPY LIMIT 35
8290	CHRONIC HOSP SPEECH THERAPY LIM 35 VIS OF 1 UNIT
8291	CHRONIC HOSP SPEECH THERAPY LIM 35 VIS IN 12 MTHS
8292	CHRONIC HOSP OCCUPATIONAL THERAPY 20 VISITS/12MTH
8293	CHRONIC HOSP PHYSICAL THERAPY LIM 20 VISITS/12MTHS
8294	REHAB CENTER PHYSICAL THERAPY LIMIT 20 VIS 12 MTH
8295	REHAB CENTER OCCUPTNL THERAPY LIMIT 20 VIS 12 MTH
8296	REHAB CENTER SPEECH THERAPY LIMIT 35 VISITS 12 MTH
8297	PSYCH INPATIENT LIMIT 30 CONSECTV DAYS PER EPISODE
8298	PSYCH INPATIENT LIMIT 60 DAYS PER CALENDAR YEAR
8299	OPERATING ROOM CONFLICTS W/AMBULATORY SURGERY
8300	INDEPENDENT PHYSICAL THERAPY LIMIT 20 VIS 12 MONTH
8301	INDEPENDENT OCCUPATIONAL THERAPY LIM 20 VIS 12 MTH
8302	ADULT & GROUP FOSTER CARE - LIMIT 31 UNITS PER MTH
8303	PA REQUIRED FOR EQUIPMENT REPAIR OVER $1,000
8400	NMLOA ALL LOC MAX 15 CUMULATIVE DAYS IN 1 DOS YEAR
8401	NMLOA ALL LOC MAX 10 CUMULATIVE DAYS IN 1 DOS YEAR
8500	2 CLAVICULECTOMIES IN LIFETIME (SURG)
8501	2 CLAVICULECTOMIES IN LIFETIME (ASSIST SURG)
8502	2 CLAVICULECTOMIES IN LIFETIME (OPD FACILITY)
8503	2 CLAVICULECTOMIES IN LIFETIME (ASC FACILITY)
8504	2 AMPUTATIONS-WRIST IN LIFETIME (SURG)
8505	2 AMPUTATIONS-WRIST IN LIFETIME (ASSIST SURG)

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8506	2 AMPUTATIONS-WRIST IN LIFETIME (OPD FACILITY)
8507	10 AMPUTATIONS-METACARPAL IN LIFE (SURG)
8508	10 AMPUTATIONS-METACARPAL IN LIFE (ASSIST SURG)
8509	10 AMPUTATIONS-METACARPAL IN LIFE (OPD FACILITY)
8510	10 AMPUTATIONS-METACARPAL IN LIFE (ASC FACILITY)
8511	2 AMPUTATIONS-ANKLE IN LIFETIME (SURG)
8512	2 AMPUTATIONS-ANKLE IN LIFETIME (ASSIST SURG)
8513	2 AMPUTATIONS-ANKLE IN LIFETIME (OPD FACILITY)
8514	2 AMPUTATION-FOOT (MID) IN LIFETIME (SURG)
8515	2 AMPUTATION-FOOT (MID) IN LIFETIME (ASSIST SURG)
8516	2 AMPUTATION-FOOT (MID) IN LIFETIME (OPD FACILITY)
8517	2 AMPUTATION-FOOT (TRN) IN LIFETIME (SURG)
8518	2 AMPUTATION-FOOT (TRN) IN LIFETIME (ASSIST SURG)
8519	2 AMPUTATION-FOOT (TRN) IN LIFETIME (OPD FACILITY)
8520	1 EPIGLOTTIDECTOMY IN LIFETIME (SURG)
8521	1 EPIGLOTTIDECTOMY IN LIFETIME (ASSIST SURG)
8522	1 EPIGLOTTIDECTOMY IN LIFETIME (OPD FACILITY)
8523	1 EPIGLOTTIDECTOMY IN LIFETIME (ASC FACILITY)
8524	1 COLPECTOMY IN LIFETIME (SURG)
8525	1 COLPECTOMY IN LIFETIME (ASSIST SURG)
8526	1 COLPECTOMY IN LIFETIME (OPD FACILITY)
8527	1 TRACHELECTOMY (CERVIECTOMY) IN LIFETIME (SURG)
8528	1 TRACHELECTOMY (CERVIECTOMY) IN LIFETIME (ASSIST SURG)
8529	1 TRACHELECTOMY (CERVIECTOMY) IN LIFETIME (OPD FACILITY)
8530	1 TRACHELECTOMY (CERVIECTOMY) IN LIFETIME (ASC FACILITY)
8531	1 THYROIDECTOMY IN LIFETIME (SURG)
8532	1 THYROIDECTOMY IN LIFETIME (ASSIST SURG)
8533	1 THYROIDECTOMY IN LIFETIME (OPD FACILITY)
8534	1 EVALUATION (99456) PER PROVIDER IN LIFETIME
8535	2 MASTECTOMIES IN LIFETIME (SURG)
8536	2 MASTECTOMIES IN LIFETIME (ASSIST SURG)
8537	2 MASTECTOMIES IN LIFETIME (OPD FACILITY)
8538	2 MASTECTOMIES IN LIFETIME (ASC FACILITY)
8539	1 MASTECTOMY IN LIFETIME-MOD 50 (INACTIVE)
8540	1 MASTECTOMY IN LIFETIME-MOD 50 (INACTIVE)
8541	10 AMPUTATIONS-FINGER IN LIFETIME (SURG)
8542	10 AMPUTATIONS-FINGER IN LIFETIME (ASSIST SURG)
8543	10 AMPUTATIONS-FINGER IN LIFETIME (OPD FACILITY)
8544	2 AMPUTATIONS-ARM IN LIFETIME (SURG)
8545	2 AMPUTATIONS-ARM IN LIFETIME (ASSIST SURG)
8546	2 AMPUTATIONS-ARM IN LIFETIME (OPD FACILITY)
8547	2 AMPUTATIONS FOREARM-THRU RADIUS & ULNA (SURG)
8548	2 AMPUTATIONS FOREARM-THRU RADIUS & ULNA (ASSIST SURG)
8549	2 AMPUTATIONS FOREARM-THRU RADIUS & ULNA (OPD FACILITY)
8550	2 AMPUTATIONS-LEG IN LIFETIME (SURG)

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EOB CODE	EOB DESCRIPTION
8551	2 AMPUTATIONS-LEG IN LIFETIME (ASSIST SURG)
8552	2 AMPUTATIONS-LEG IN LIFETIME (OPD FACILITY)
8553	2 AMPUTATIONS LEG- TIBIA & FIBULA- LIFETIME (SURG)
8554	2 AMPUTATIONS LEG- TIBIA & FIBULA- LIFETIME (ASSIST SURG)
8555	2 AMPUTATIONS LEG- TIBIA & FIBULA- LIFETIME (OPD FACILITY)
8556	1 LARYNGECTOMY IN LIFETIME (SURG)
8557	1 LARYNGECTOMY IN LIFETIME (ASSIST SURG)
8558	1 LARYNGECTOMY IN LIFETIME (OPD FACILITY)
8559	1 HEMILARYNGECTOMY IN LIFETIME (SURG)
8560	1 HEMILARYNGECTOMY IN LIFETIME (ASSIST SURG)
8561	1 HEMILARYNGECTOMY IN LIFETIME (OPD FACILITY)
8562	1 TOTAL PNEUMONECTOMY IN LIFETIME (SURG)
8563	1 TOTAL PNEUMONECTOMY IN LIFETIME (ASSIST SURG)
8564	1 TOTAL PNEUMONECTOMY IN LIFETIME (OPD FACILITY)
8565	1 GLOSSECTOMY IN LIFETIME (SURG)
8566	1 GLOSSECTOMY IN LIFETIME (ASSIST SURG)
8567	1 GLOSSECTOMY IN LIFETIME (OPD FACILITY)
8568	1 APPENDECTOMY IN LIFETIME (SURG)
8569	1 APPENDECTOMY IN LIFETIME (ASSIST SURG)
8570	1 APPENDECTOMY IN LIFETIME (OPD FACILITY)
8571	1 TOTAL GASTRECTOMY IN LIFETIME (SURG)
8572	1 TOTAL GASTRECTOMY IN LIFETIME (ASSIST SURG)
8573	1 TOTAL GASTRECTOMY IN LIFETIME (OPD FACILITY)
8574	1 AMPUTATION-PENIS IN LIFETIME (SURG)
8575	1 AMPUTATION-PENIS IN LIFETIME (ASSIST SURG)
8576	1 AMPUTATION-PENIS IN LIFETIME (OPD FACILITY)
8577	1 CIRCUMCISION IN LIFETIME (SURG)
8578	1 CIRCUMCISION IN LIFETIME (ASSIST SURG)
8579	1 CIRCUMCISION IN LIFETIME (OPD FACILITY)
8580	1 CIRCUMCISION IN LIFETIME (ASC FACILITY)
8581	2 ORCHIECTOMIES-UNILAT IN LIFETIME (SURG)
8582	2 ORCHIECTOMIES-UNILAT IN LIFETIME (ASSIST SURG)
8583	2 ORCHIECTOMIES-UNILAT IN LIFETIME (OPD FACILITY)
8584	2 ORCHIECTOMIES-UNILAT IN LIFETIME (ASC FACILITY)
8585	1 ORCHIECTOMY- BILATERAL IN LIFETIME (INACTIVE)
8586	1 ORCHIECTOMY- BILATERAL IN LIFETIME (INACTIVE)
8587	1 PROSTATECTOMY IN LIFETIME (SURG)
8588	1 PROSTATECTOMY IN LIFETIME (ASSIST SURG)
8589	1 PROSTATECTOMY IN LIFETIME (OPD FACILITY)
8590	1 VULVECTOMY IN LIFETIME (SURG)
8591	1 VULVECTOMY IN LIFETIME (ASSIST SURG)
8592	1 VULVECTOMY IN LIFETIME (OPD FACILITY)
8593	1 VULVECTOMY IN LIFETIME (ASC FACILITY)
8594	1 EXCISION OF CERVICAL STUMP IN LIFETIME (SURG)
8595	1 EXCISION OF CERVICAL STUMP IN LIFETIME (ASSIST SURG)

MassHealth List of EOB Codes Appearing on the Remittance Advice

EOB CODE	EOB DESCRIPTION
8596	1 EXCISION OF CERVICAL STUMP IN LIFETIME (OPD FACILITY)
8597	1 TRACHELECTOMY IN LIFETIME (SURG)
8598	1 TRACHELECTOMY IN LIFETIME (ASSIST SURG)
8599	1 TRACHELECTOMY IN LIFETIME (OPD FACILITY)
8600	1 TRACHELECTOMY IN LIFETIME (ASC FACILITY)
8601	1 HYSTERECTOMY IN LIFETIME (SURG)
8602	1 HYSTERECTOMY IN LIFETIME (ASSIST SURG)
8603	1 HYSTERECTOMY IN LIFETIME (OPD FACILITY)
8604	2 ADRENALECTOMIES IN LIFETIME (SURG)
8605	2 ADRENALECTOMIES IN LIFETIME (ASSIST SURG)
8606	2 ADRENALECTOMIES IN LIFETIME (OPD FACILITY)
8607	1 ADRENALECTOMY IN LIFETIME (INACTIVE)
8608	2 COMPLETE IRIDECTOMIES IN LIFETIME (SURG)
8609	2 COMPLETE IRIDECTOMIES IN LIFETIME (ASSIST SURG)
8610	2 COMPLETE IRIDECTOMIES IN LIFETIME (OPD FACILITY)
8611	2 COMPLETE IRIDECTOMIES IN LIFETIME (ASC FACILITY)
8612	1 PALATOPLASTY FOR CLEFT PALATE IN LIFETIME (SURG)
8613	1 PALATOPLASTY FOR CLEFT PALATE IN LIFETIME (ASSIST SURG)
8614	1 PALATOPLASTY FOR CLEFT PALATE IN LIFETIME (OPD FACILITY)
8615	1 PALATOPLASTY FOR CLEFT PALATE IN LIFETIME (ASC FACILITY)
9000	PHARMACY ALLOWED AMOUNT IS LESS THAN BILLED AMOUNT
9001	REIMBURSEMENT REDUCED BY THE RECIPIENT'S CO-PAYMENT AMOUNT.
9002	PRICING METHOD MISSING/INVALID FOR CLAIM TYPE
9005	CLAIM PAYMENT AMOUNT LESS THAN COPAY AMOUNT
9010	MEMBER HAS MET COPAY CAP
9011	CO-PAYMENT INCLUSION CRITERIA NOT MET
9013	MEMBER CALENDAR COINSURANCE LIMIT EXCEEDED
9015	AT LEAST ONE DETAIL IS IN DENIED STATUS
9016	CLAIM DENIED BECAUSE ALL DETAILS DENIED
9020	CRITICAL EDIT IS RECYCLED TO A PAY EDIT
9050	COLLECTION FROM TITLE 18(MEDICARE PART-A) FOR SERVICES PREVIOUSLY PAID BY MCARE
9051	COLLECTION FROM TITLE 18(MEDICARE PART-B) FOR SERVICES PREVIOUSLY PAID BY MCARE
9052	COLLECTION FROM ANY HEALTH INSURANCES
9053	COLLECTION FROM CASUALTY INSURANCE, WORKMANS COMP, OR TORT LIABILITY CLAIMS
9054	COLLECTION FROM ESTATE OF DECEASED MEMBER
9055	MANUAL ADJUSTMENT
9056	GENERAL MASS ADJUSTMENT
9057	PAID TO WRONG PROVIDER
9058	PAID FOR WRONG MEMBER
9059	PROVIDER BILLED SERVICE PRIOR TO SERVICE DATE/SERVICE NOT DELIVERED
9060	DUPLICATE PAYMENT RETURNED DUE TO AN ERRONEOUS DUPLICATE PAYMENT FOR SAME DATE
9061	DUPLICATE PAYMENT - PROVIDER BILLED TWICE
9062	COLLECTION FROM CREDIT BALANCE ON MEMBERS ACCOUNTS
9063	PROVIDER PAID MORE THAN BILLED
9064	PROVIDER ONLY PERFORMED COMPONENT OF SERVICE BILLED

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EOB CODE	EOB DESCRIPTION
9065	OTHER
9066	PATIENT PAID AMOUNT DISCREPANCY
9067	COLLECTION FROM TITLE 18 WHEN PART A OR B CANNOT BE DETERMINED
9068	LEAVE OF ABSENCE DAYS WERE EITHER NOT INDICATED OR INCORRECT
9069	OUTPATIENT CLAIM WAS BILLED DURING AN INPATIENT STAY
9070	OUTPATIENT CLAIM WAS BILLED DURING AN INPATIENT STAY - SAME FACILITY
9071	LONG TERM CARE CLAIM WAS BILLED DURING A HOSPICE SEGMENT
9072	CLAIM WAS PAID AN INCORRECT PRICE
9073	MEDICAL RECORD WAS NOT SUBMITTED FOR POST-PAYMENT REVIEW
9074	MEDICAL NECESSITY WAS NOT DETERMINED BY POST-PAYMENT REVIEW
9075	CLAIM WAS VOIDED AFTER MEDICAL REVIEW
9076	ADJUSTMENT DUE TO RETROACTIVE MANAGED CARE ENROLLMENT
9077	CLAIM REJECTED BY MH
9078	PROVIDER BILLED INCORRECTLY
9084	MANUAL ADJUSTMENT BY BATCH
9100	90 DAY WAIVER DENIED. THE MASSHEALTH REMITTANCE ADVICE REFERENCED IN YOUR LETTER IS MISSING
9103	90 DAY WAIVER DENIED. THE MASSHEALTH REMITTANCE ADVICE PROVIDED DOES NOT PERTAIN TO THE CLAIMS SUBMITTED
9106	90 DAY WAIVER DENIED. THE MASSHEALTH REMITTANCE ADVICE PROVIDED BELONGS TO A CLAIM THAT IS IN SUSPENSE
9109	90 DAY WAIVER DENIED. THE MASSHEALTH REMITTANCE ADVICE PROVIDED BELONGS TO A CLAIM THAT HAS ALREADY PAID
9112	90 DAY WAIVER DENIED. THE EXPLANATION OF BENEFITS (EOB) FROM THE OTHER INSURER IS MISSING
9115	90 DAY WAIVER DENIED. A COPY OF THE RETROACTIVE ENROLLMENT NOTICE IS MISSING
9118	90 DAY WAIVER DENIED. DOCUMENTATION PROVIDED DOES NOT MATCH THE NAME(S) AND/OR DATES OF SERVICE(S) ON THE CLAIMS
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
9124	90 DAY WAIVER DENIED. A COPY OF A STATEMENT/BILL SENT TO THE MEMBER IS MISSING
9127	90 DAY WAIVER DENIED. A COPY OF THE RETROACTIVE PRIOR AUTHORIZATION NOTICE IS MISSING
9130	90 DAY WAIVER DENIED. A COPY OF THE RETROACTIVE PRE-ADMISSION SCREENING NOTICEIS MISSING
9133	90 DAY WAIVER DENIED. A COPY OF THE NOTIFICATION OF BIRTH (NOB) OR ENROLLMENT NOTICE IS MISSING
9136	90 DAY WAIVER DENIED. A COPY OF THE PIP EXHAUSTION NOTICE IS MISSING
9139	90 DAY WAIVER DENIED. THE SERVICE DATE EXCEEDS ONE YEAR
9142	90 DAY WAIVER DENIED. THE SERVICE DATE EXCEEDS 18 MONTHS
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
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
9151	90 DAY WAIVER DENIED. A COPY OF THE ELIGIBILITY VERIFICATION PRINTOUT REFERENCED IN YOUR LETTER IS MISSING
9154	90 DAY WAIVER DENIED. REQUEST DOES NOT COMPLY WITH MASSHEALTH REGULATIONS
9157	90 DAY WAIVER DENIED. THE MEMBER'S ID WAS NOT CHANGED
9160	90 DAY WAIVER DENIED. THE ORIGINAL EDI CLAIM(S) WERE NOT RECEIVED TIMELY
9163	90 DAY WAIVER DENIED. THE ORIGINAL EDI CLAIM(S) WERE RECEIVED TIMELY AND CAN BE RESUBMITTED
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
9700	CLAIM WAS DENIED DUE TO A POS REVERSAL

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MassHealth List of EOB Codes Appearing on the Remittance Advice

EOB CODE	EOB DESCRIPTION
9701	MEMBER LINKING CLAIM ADJUSTMENT
9702	PROVIDER RECOUPED CLAIM
9800	MAXIMUM PAYMENT ALLOWED FOR HMO/COV
9875	NON-MEDICAL LEAVE DAYS LIMIT EXCEEDED
9901	REIMBURSEMENT LIMITED TO ONE SET OF FRAMES PER YEAR FOR RECIPIENTS 18 YEARS
9905	PRICE REDUCED TO SPAD PAYMENT
9907	TPL AMOUNT APPLIED
9910	PHARMACY DISPENSING FEE APPLIED
9916	UCC RATE PRICING APPLIED
9918	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED
9919	PROVIDER LEVEL OF CARE PRICING APPLIED
9921	PA (PRIOR AUTHORIZATION) PRICING APPLIED
9922	SPENDDOWN DEDUCTIBLE APPLIED
9928	COB-TPL COST SAVINGS
9932	PRICING ADJUSTMENT - DRG PRICING APPLIED
9933	AMOUNT CUTBACK DUE TO APC PRICING
9997	PERSONAL RESOURCES DEDUCTED FROM THE CLAIM ARE A RESULT OF PREVIOUS
9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT HEALTH COVERAGE PROGRAM POLICIES
9999	CLAIM HAS CUTBACK AMOUNT