EOB Crosswalk

PAPER		ELECTRONIC			
EOB Code	EOB Description	Remark Code	Remark Description	Adjustment Reason	Adjustment Description
001	THIS IS AN EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM.	N522	DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM.	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
002	THIS IS A POSSIBLE DUPLICATE OF A PREVIOUSLY PAID CLAIM. MULTIPLE CLAIMS CANNOT BE BILLED WITH OVERLAPPING DATES OR CHARGES FOR A RECIPIENT.	N522	DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM.	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
003	THIS SERVICE/PROCEDURE BILLED DOES NOT MEET IOWA MEDICAID HEALTH HOME PROGRAM GUIDELINES.		...	272	COVERAGE/PROGRAM GUIDELINES WERE NOT MET
004	THE MEDICAID SERVICE LIMIT FOR THIS SERVICE HAS BEEN EXCEEDED. IF UNUSUAL CIRCUMSTANCES ARE DOCUMENTED, MEDICAL REVIEW CAN BE REQUESTED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
005	PAYMENT FOR THESE SERVICES ARE INCLUDED IN THE FEE FOR A CLAIM THAT HAS BEEN PAID PREVIOUSLY. MULTIPLE MEDICAL SERVICES ARE NOT PAYABLE.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
006	THE PROCEDURE IS COVERED IN THE SURGERY FOLLOW-UP PERIOD AND WILL NOT BE PAID SEPARATELY.	M144	PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
007	THE SERVICE BILLED REPRESENTS A FRAGMENTATION WITH SERVICES PREVIOUSLY BILLED FOR THE SAME DATE. MULTIPLE MEDICAL SERVICES ARE NOT PAYABLE.	N20	SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...

008	EACH LINE ITEM BILLED CANNOT CONTAIN DATES OF SERVICE THAT OVERLAP MONTHS. THE MAXIMUM PER LINE ITEM IS ONE CALENDAR MONTH.	N74	RESUBMIT WITH MULTIPLE CLAIMS, EACH CLAIM COVERING SERVICES PROVIDED IN ONLY ONE CALENDAR MONTH.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
009	THE ADMISSION DATE IS AFTER THE FIRST DATE OF SERVICE.	MA40	MISSING/INCOMPLETE/INVALID ADMISSION DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
011	THE FIRST PROCEDURE CODE MODIFIER IS NOT A VALID VALUE FOR IOWA MEDICAID. ENTER THE CORRECT MODIFIER AND RESUBMIT THE CLAIM.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
012	THE SECOND PROCEDURE CODE MODIFIER IS NOT A VALID VALUE FOR IOWA MEDICAID. ENTER THE CORRECT MODIFIER AND RESUBMIT THE CLAIM.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
013	A DENTAL SEALANT OR MEDICAMENT APPLICATION HAS PREVIOUSLY BEEN PAID FOR THIS TOOTH.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
014	MULTIPLE AMBULANCE TRIPS WERE BILLED ON THIS DATE. MEDICAL NECESSITY WAS NOT ESTABLISHED FOR MULTIPLE TRIPS.	N115	THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,...	50	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
015	THE SERVICES BILLED REPRESENT AN OBSTETRICAL PANEL AND MUST BE BILLED WITH CODE 80055.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...

016	THE SERVICE DATE IS MISSING OR INVALID. ENTER THE CORRECT DATE OF SERVICE AND RESUBMIT THE CLAIM.	M52	MISSING/INCOMPLETE/INVALID "FROM" DATE(S) OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
017	LONG TERM CARE VISITS NOT ALLOWED ON SAME DOS AS COMPREHENSIVE MEDICAL VISITS BY THE SAME PROVIDER WITHOUT DOCUMENTATION OF MEDICAL NECESSITY.	M80	NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
018	THE FIRST DATE OF SERVICE IS AFTER THE LAST DATE OF SERVICE.	M52	MISSING/INCOMPLETE/INVALID "FROM" DATE(S) OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
019	CLAIM EXCEEDS THE 12 MONTH TIMELY FILING LIMIT.		...	29	THE TIME LIMIT FOR FILING HAS EXPIRED
020	THE RECIPIENT NUMBER IS MISSING. ENTER THE CORRECT 8-POSITION RECIPIENT ID NUMBER IN THE CORRECT FIELD AND RESUBMIT THE CLAIM.		...	31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED
021	ONLY ONE HOSPITAL DISCHARGE MANAGEMENT CODE CAN BE BILLED PER ADMISSION.	N50	MISSING/INCOMPLETE/INVALID DISCHARGE INFORMATION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
022	INITIAL NICU CARE IS PAYABLE ONLY FOR INITIAL CARE AT TIME OF PATIENT'S BIRTH.	N113	ONLY ONE INITIAL VISIT IS COVERED PER PHYSICIAN, GROUP PRACTICE OR PROVIDER.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

023	INVALID OR MISSING ADMISSION TYPE. PLEASE UPDATE CLAIM AND RESUBMIT. VALID VALUES ARE 1-5 FOR ADMISSION TYPE.	MA40	MISSING/INCOMPLETE/INVALID ADMISSION DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
024	THE PAYOR CODE IS NOT A VALID VALUE, OR ONE OF THE PAYOR CODES IS NOT EQUAL TO 1 INDICATING MEDICAID.	M56	MISSING/INCOMPLETE/INVALID PAYER IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
025	THE TYPE OF BILL IS NOT A VALID VALUE. REFER TO YOUR BILLING MANUAL TO FIND THE CORRECT TYPE OF BILL FOR THE CLAIM AND RESUBMIT.	MA30	MISSING/INCOMPLETE/INVALID TYPE OF BILL.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
026	LENGTH OF STAY EXCEEDED FOR DIAGNOSIS		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
027	MULTIPLE/FRAGMENTED METHODS OF ADMINISTRATION HAVE BEEN BILLED.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
028	THE MEDICAID MAXIMUM FOR CROWNS IS TWO PER 12 MONTH PERIOD. THIS MAXIMUM HAS BEEN EXCEEDED.	M90	NOT COVERED MORE THAN ONCE IN A 12 MONTH PERIOD.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

029	THE PATIENT STATUS IS INVALID. PLEASE REFER TO YOUR BILLING MANUAL FOR THE VALID VALUES.	MA43	MISSING/INCOMPLETE/INVALID PATIENT STATUS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
030	THE NUMBER OF DAYS BILLED IS NOT EQUAL TO THE ROOM AND BOARD UNITS.	M52	MISSING/INCOMPLETE/INVALID "FROM" DATE(S) OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
031	THE DATE OF SERVICE IS AFTER THE DATE THE CLAIM WAS RECEIVED.		...	110	BILLING DATE PREDATES SERVICE DATE
032	THE MAXIMUM AMOUNT OF CRITICAL CARE BILLABLE UNDER THIS CODE IS ONE HOUR PER DATE OF SERVICE.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
033	THE PROCEDURE CODE IS NOT APPROVED FOR BILLING AMBULANCE SERVICES OR IS INAPPROPRIATELY BILLED	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
034	THE MAXIMUM NUMBER OF SERVICES ALLOWABLE FOR THE PROCEDURE BILLED HAS BEEN EXCEEDED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
035	THE LINE ITEM REVENUE CODE IS MISSING.	M50	MISSING/INCOMPLETE/INVALID REVENUE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
036	THE SERVICE LIMIT FOR DENTAL EXAMS/X-RAYS HAS BEEN EXCEEDED. CHECK THE DATE OF THE LAST EXAM BASED ON PROVIDER MANUAL CRITERIA.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED

037	A MEDICARE PAID AMOUNT IS SHOWN ON THE CLAIM FORM. IF THIS IS CORRECT, A MEDICARE EOMB MUST BE SUBMITTED FOR DEDUCTIBLE/COINSURANCE PROCESSING.	N479	MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER).	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
038	THERE IS A MAXIMUM OF ONE DISPENSING FEE PER MONAURAL OR TWO FEES FOR BINAURAL AIDS WITHOUT PRIOR APPROVAL IN FOUR YEARS. THIS WAS EXCEEDED.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
039	THE NDC (DRUG) CODE IS MISSING. ENTER THE CORRECT NDC CODE AND RESUBMIT THE CLAIM.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
040	THE NUMBER OF SERVICES ALLOWED FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
041	THE PRESCRIPTION NUMBER IS MISSING OR INVALID. CORRECT THE PRESCRIPTION NUMBER AND RESUBMIT THE CLAIM.		...	175	PRESCRIPTION IS INCOMPLETE
042	THE QUANTITY OF THE DISPENSED DRUG IS ZEROES. ENTER THE CORRECT DRUG QUANTITY AND RESUBMIT THE CLAIM.	N378	MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
043	THE RECIPIENT IS OLDER THAT THE MAXIMUM AGE ALLOWED TO RECEIVE THIS SERV ICE.	N129	NOT ELIGIBLE DUE TO THE PATIENT'S AGE.	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
044	THE TOTAL CLAIM CHARGE AMOUNT AND THE SUM OF THE LINE ITEM CHARGES ARE NOT EQUAL.	M54	MISSING/INCOMPLETE/INVALID TOTAL CHARGES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

045	THE DIAGNOSIS OR THE LINE ITEM DIAGNOSIS IS MISSING. CORRECT THE DIAGNOSIS CODE ANDD RESUBMIT THE CLAIM.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
046	ONLY ONE VISIT/TREATMENT/ENCOUNTER IS PAYABLE PER DATE OF SERVICE. ADDITIONAL SERVICES DO NOT MEET CONCURRENT CARE GUIDELINES.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	B14	ONLY ONE VISIT OR CONSULTATION PER PHYSICIAN PER DAY IS COVERED
047	THE RECIPIENT'S AGE IS INVALID FOR THE DRG ASSIGNED BY THE DRG GROUPER.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
048	THE CROSSOVER DEDUCTIBLE AMOUNT EXCEEDS THE ALLOWED DEDUCTIBLE LIMIT FOR THE YEAR THAT THE SERVICE WAS PERFORMED.	N23	ALERT: PATIENT LIABILITY MAY BE AFFECTED DUE TO COORDINATION OF BENEFITS WITH OTHER CARRIERS AND/OR MAXIMUM BENEFIT PROVISIONS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
049	THE ADMISSION DATE OR ACTION CODE IS MISSING OR INVALID.	MA40	MISSING/INCOMPLETE/INVALID ADMISSION DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
050	A URINALYSIS IS CONSIDERED PART OF ROUTINE PRENATAL CARE AND IS NOT PAYABLE SEPARATELY.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
051	ONLY ONE CONSULTATION IS PAYABLE PER RECIPIENT/PER PROVIDER. SUBSEQUENT CONSULTATIONS MUST BE BILLED AS OFFICE/HOSPITAL VISITS.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
052	THE SERVICE LIMIT FOR THIS EXCEPTION TO POLICY SERVICE HAS BEEN EXCEEDED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED

053	THE NUMBER OF TREATMENTS EXCEEDS THE MAXIMUM NUMBER ALLOWED BY MEDICAID.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
054	ANY ONE OF THE LINE ITEM PROCEDURE DATES IS AFTER THE DATE THE CLAIM WAS RECEIVED.		...	110	BILLING DATE PREDATES SERVICE DATE
055	THE ADMISSION SOURCE IS MISSING OR INVALID. VALID VALUES ARE 1-9 AND D.	MA42	MISSING/INCOMPLETE/INVALID ADMISSION SOURCE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
057	REQUIRED NDC MISSING, INVALID OR NOT ON THE PREFERRED LIST. DIABETIC SUPPLY (MONITOR/STRIP/SYRINGE/LANCET) REQUIRES NDC	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
058	MULTIPLE ECHOGRAPHY CODES CANNOT BE BILLED ON THE SAME DATE IF A COMPLETE PROCEDURE IS ALSO BILLED.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
059	AN EXAMINATION CANNOT BE BILLED ON THE SAME DAY AS AN EYE REFRACTION. A REFRACTION IS PAYABLE SEPARATELY ONLY WHEN MEDICARE PAYS THE EXAM.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
060	THE DISCHARGE DATE OR TERMINATION CODE IS MISSING OR INVALID.	N318	MISSING/INCOMPLETE/INVALID DISCHARGE OR END OF CARE DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

061	FRAGMENTED OB SERVICES WERE BILLED. OB DELIVERY MUST BE BILLED AS A GLOBAL CHARGE - C-SECTION OR OBSTETRICAL DELIVERY.	M144	PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
062	THE 1ST SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE.	N301	MISSING/INCOMPLETE/INVALID PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
063	THE 2ND SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
064	THE 3RD SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
065	THE 4TH SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
066	THE 5TH SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

067	THE SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
068	INVALID DATES WERE BILLED AS "FROM/THROUGH" DATES OF SERVICE.	MA31	MISSING/INCOMPLETE/INVALID BEGINNING AND ENDING DATES OF THE PERIOD BILLED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
069	1ST SURGICAL PROCEDURE CODE IS MISSING & THE REVENUE CODE INDICATES A SURGERY WAS PERFORMED. RESUBMIT THE CLAIM WITH CORRECT SURG. PROC. CODE.	MA66	MISSING/INCOMPLETE/INVALID PRINCIPAL PROCEDURE CODE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
070	THE 1ST SURGICAL PROCEDURE CODE DOES NOT HAVE A CORRESPONDING SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT 1ST SURGICAL PROCEDURE DATE.	N303	MISSING/INCOMPLETE/INVALID PRINCIPAL PROCEDURE DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
071	THE 2ND SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT SECOND SURGICAL PROCEDURE DATE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
072	THE 3RD SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT THIRD SURGICAL PROCEDURE DATE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

073	THE 4TH SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT FOURTH SURGICAL PROCEDURE DATE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
074	5TH DIAGNOSIS INCORRECT AS SUBMITTED. PLEAS CORRECT AND RESUBMIT CLAIM.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
075	THE 5TH SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT FIFTH SURGICAL PROCEDURE DATE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
076	THE REFERRING PROVIDER NUMBER IS ZEROES.	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
077	THE SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE RESUBMIT THE CLAIM WITH THE CORRECT SURGICAL PROCEDURE DATE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
078	THE NUMBER OF DAYS BILLED DO NOT MATCH THE FIRST DATE OF SERVICE THROUGH THE LAST DATE OF SERVICE.	N345	DATE RANGE NOT VALID WITH UNITS SUBMITTED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

079	MAXIMUM LIMIT EXCEEDED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
080	THE BILLING PROVIDER NUMBER IS A TREATING PROVIDER. A SEPARATE GROUP NUMBER MUST BE SHOWN FOR THE PAY-TO PROVIDER IN THE CORRECT FIELD.	N55	PROCEDURES FOR BILLING WITH GROUP/REFERRING/PERFORMING PROVIDERS WERE NOT FOLLOWED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
081	THIS SERVICE IS CONSIDERED A MEDICARE-COVERED SERVICE. THE CLAIM DID NOT MEET MEDICAID PAYMENT CRITERIA FOR DIRECT MEDICAID BILLING.	N479	MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
082	ONLY ONE MEDICAL CASE MANAGEMENT IS ALLOWED PER CALENDAR MONTH.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
083	THIS ITEM HAS BEEN PREVIOUSLY PURCHASED AND IS NOT ELIGIBLE FOR ANOTHER PURCHASE AT THIS TIME. IF THIS WAS RENTAL, MODIFIER RR IS REQUIRED.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	108	RENT/PURCHASE GUIDELINES WERE NOT MET. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
084	12 EMERGENCY RESPONSE CLAIMS ARE PAYABLE PER 12 MONTH PERIOD (ONE PER MONTH). THIS NUMBER HAS BEEN EXCEEDED.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
085	THE RECIPIENT ID NUMBER IS NOT ON FILE. THE CLAIM MUST BE RESUBMITTED WITH THE CORRECT RECIPIENT ID NUMBER.		...	31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED
086	FRAGMENTED X-RAY CHARGES WERE BILLED. BITEWINGS OR PANORAMIC X-RAY CANNOT BE BILLED IN ADDITION TO A FULL-MOUTH X-RAY.	N20	SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
087	THE SERVICE LIMIT FOR THIS CONDITION HAS BEEN EXCEEDED BASED ON DIAGNOSES SUBMITTED ON THE CLAIM.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
088	THE 7TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

089	THE SERVICE LIMIT FOR THE PROCEDURE BILLED HAS BEEN EXCEEDED OR THIS REPRESENTS FRAGMENTATION WITH OTHER SERVICES BILLED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
090	THE RECIPIENT HAS THIRD-PARTY INSURANCE AND NO INSURANCE PAYMENT OR DENIAL IS SHOWN ON THE CLAIM.	MA04	SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER NOT REPORTED OR WAS ILLEGIBLE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
091	MULTIPLE SURGERIES WERE BILLED ON THIS DATE. DOCUMENTATION WAS NOT PROVIDED TO SUPPORT THE PROCEDURE CODES BILLED.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
092	HYSTERECTOMY CLAIM IS IN PROCESS FOR REVIEW.		...	133	THE DISPOSITION OF THIS SERVICE LINE IS PENDING FURTHER REVIEW. (USE ONLY WITH GROUP CODE OA). USAGE: USE OF THIS CODE REQUIRES A REVERSAL AND CORRECTION WHEN THE SERVICE LINE IS FINALIZED (USE ONLY IN LOOP 2110 CAS SEGMENT OF THE 835 OR LOOP 2430 OF ...
093	THE SERVICE LIMIT MAXIMUM HAS BEEN EXCEEDED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
094	BILLING NPI NUMBER AND/OR TAXONOMY AND/OR ZIP IS MISSING OR INVALID	N257	MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
095	THE MEDICAID SERVICE LIMIT FOR THIS SERVICE HAS BEEN EXCEEDED. IF UNUSUAL CIRCUMSTANCES ARE DOCUMENTED, MEDICAL REVIEW CAN BE REQUESTED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
096	THE RECIPIENT IS NOT ELIGIBLE FOR FULL MEDICAID COVERAGE. ELIGIBILITY IS FOR COINSURANCE/DEDUCTIBLE ON MEDICARE-COVERED SERVICES.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

097	SERVICE NOT COVERED FOR RECIPIENT. THE STATE ELIGIBILITY FILE SHOWS LIMITED OR NO MEDICAID ELIGIBILITY FOR THE DATE OF SERVICE.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
098	THE RECIPIENT IS IN THE LOCK-IN PROGRAM. THE BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES.		...	242	SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS
099	INVALID ICD-10 PRINCIPAL DIAGNOSIS CODE	MA63	MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
100	DIAGNOSIS BILLEDIS NOT A REASON FOR HOSPITAL SERVICE BASED ON APG/DRG GROUPER. DIAGNOSIS BILLED MUST BE 5 DIGIT CODE IF 5 DIGITS ARE AVAILABLE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
101	THE REFERRING PROVIDER NUMBER IS NOT A VALID MEDICAID PROVIDER NUMBER OR HAS BEEN TERMED BY THE MEDICAID AUTHORITY FOR THE DATE OF SERVICE.	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
102	THE SUBMITTER IS NOT ALLOWED TO SUBMIT ELECTRONIC CLAIMS FOR THE BILLING PROVIDER.	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

103	CONCURRENT CARE WAS PROVIDED. THIS SERVICES REPRESENTS A DUPLICATION OR OVERLAP OF SERVICES PROVIDED BY THE SAME OR A DIFFERENT PROVIDER.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
104	THE EIGHTH DIAGNOSIS CODE IS NOT COVERED BY MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
105	THE SPECIAL ABSTRACT TRANSACTION CONTAINED AN ERROR WHICH CAUSED THE CLAIM TO DENY. CONTACT PROVIDER RELATIONS.		...	107	THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT IDENTIFIED ON THIS CLAIM. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
106	INCORECT GROSS ADJUSTMENT AMOUNT FOR A DEBIT. PLEASE CORRECT AND RESUBMIT CLAIM.	M54	MISSING/INCOMPLETE/INVALID TOTAL CHARGES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
107	INCORECT GROSS ADJUSTMENT AMOUNT FOR A CREDIT. PLEASE CORRECT AND RESUBMIT CLAIM.	M54	MISSING/INCOMPLETE/INVALID TOTAL CHARGES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
108	THIS ITEM OR SERVICE CANNOT BE PAID FOR RESIDENTS OF A NURSING HOME. THE CHARGE MUST BE BILLED TO THE FACILITY.	N79	SERVICE BILLED IS NOT COMPATIBLE WITH PATIENT LOCATION INFORMATION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
109	REIMBURSEMENT HAS NOT BEEN AUTHORIZED FOR THE SERVICE BILLED.		...	197	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT ABSENT

110	MISSING OR INVALID LEVEL OF CARE. CORRECT AND RESUBMIT THE CLAIM.	N188	THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
111	IOWA MEDICAID DOES NOT PAY FOR A RELATED MEDICAL VISIT FALLING WITHIN THE SURGERY PRE-OP PERIOD.	M144	PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
112	PROVIDER ENROLLMENT RECORDS DO NOT SHOW THE PROVIDER AUTHORIZED TO BILL THIS SERVICE.	N570	MISSING/INCOMPLETE/INVALID CREDENTIALING DATA.	B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
113	THE PROCEDURE CODE BILLED IS NOT VALID FOR THIS WAIVER TYPE. .	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
114	THE RECIPIENT'S AGE IS OUTSIDE THE RANGE ALLOWABLE FOR THE DIAGNOSIS BASED ON THE ICD-9-CM DESCRIPTION.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
115	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE DIAGNOSIS/PROCEDURE BILLED BASED ON THE CODE'S DESCRIPTION.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
116	PROVIDER NUMBER BILLED DOES NOT INDICATE AN ANESTHESIOLOGIST. ONLY AN ANESTHESIOLOGIST CAN MEDICALLY DIRECT A CRNA - MODIFIER AB OR AC.		...	8	THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

117	MEDICAL VISITS ARE NOT PAYABLE SEPARATELY WHEN BILLED DURING PRE & POST OP PERIOD. PRE & POST-OP VISITS ARE PART OF SURGICAL FEE.	M144	PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
118	THERE WAS TPL INDICATED ON THE CLAIM BUT NOT ON THE RECIPIENT'S FILE.	MA92	MISSING PLAN INFORMATION FOR OTHER INSURANCE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
119	THE TYPE OF BILL SHOWN ON THE UB 04 IS NOT A TYPE OF BILL APPROVED FOR THE PROVIDER BILLING THE SERVICE TO IOWA MEDICAID.	MA30	MISSING/INCOMPLETE/INVALID TYPE OF BILL.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
120	THE PROVIDER NUMBER SUBMITTED IS INCORRECT, PLEASE CORRECT AND RESUBMIT THE CLAIM.	N257	MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
121	THE BILLING PROVIDER NUMBER IS NOT ON THE PROVIDER MASTER FILE.		...	208	NATIONAL PROVIDER IDENTIFIER - NOT MATCHED
122	THIS IS AN EPSDT DIAGNOSIS CODE AND THE RECIPIENT IS 21 OR OLDER.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
123	THE QUANTITY DISPENSED FOR THE NDC IS BELOW THE MINIMUM QUANTITY.	N378	MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

124	THE QUANTITY DISPENSED FOR THE NDC IS GREATER THAN THE MAXIMUM QUANTITY.	N378	MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
125	THE RECIPIENT IS YOUNGER THAN THE MINIMUM AGE ALLOWED TO RECEIVE THIS DRUG.	M123	MISSING/INCOMPLETE/INVALID NAME, STRENGTH, OR DOSAGE OF THE DRUG FURNISHED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
126	THE RECIPIENT IS OLDER THAN THE MAXIMUM AGE ALLOWED TO RECEIVE THIS DRUG.	M123	MISSING/INCOMPLETE/INVALID NAME, STRENGTH, OR DOSAGE OF THE DRUG FURNISHED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
127	THE DIAGNOSIS BILLED IS EITHER NON-PAYABLE OR REQUIRES ADDITIONAL DIAGNOSIS IN ORDER TO MEET MEDICAL NECESSITY CRITERIA.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
128	THE DIAGNOSIS BILLED REQUIRES AN ATTACHMENT - THE STERILIZATION CONSENT FORM, THE ABORTION CERTIFICATION, THE HYSTERECTOMY STATEMENT, ETC.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
129	THE DIAGNOSIS CODE BILLED IS NOT A VALID DIAGNOSIS CODE FOR IOWA MEDICAID.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

130	DIAGNOSIS CODE IS NOT COVERED AS BILLED. IF APPLICABLE, CLAIM CAN BE RESUBMITTED WITH AN ADDITIONAL OR CORRECTED DIAGNOSIS.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
131	MODIFIER FOR PROCEDURE CODE IS INVALID FOR HOSPITAL PLACE OF SERVICE.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
132	THE TOTAL CLAIM CHARGE IS ZEROES, OR THE LINE ITEM SUBMITTED CHARGE IS ZEROES. ZERO CHARGES ARE ACCEPTABLE FOR VACCINE REPLACEMENT.	M79	MISSING/INCOMPLETE/INVALID CHARGE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
133	THE NDC BILLED IS NOT COVERED BY IOWA MEDICAID.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	204	THIS SERVICE/EQUIPMENT/DRUG IS NOT COVERED UNDER THE PATIENT'S CURRENT BENEFIT PLA
134	THE BILLED PROCEDURE REQUIRES A MODIFIER.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
135	OXYGEN HAS PREVIOUSLY BEEN BILLED FOR DATES OVERLAPPING THIS CLAIM. THESE TWO TYPES OF OXYGEN CANNOT BE BILLED SIMULTANEOUSLY.	M80	NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
136	THE CALCULATED CHARGE IS EQUAL TO ZERO OR THE CALCULATED ALLOWED CHARGE IS LESS THAN THE THIRD-PARTY INSURANCE AMOUNT.	N58	MISSING/INCOMPLETE/INVALID PATIENT LIABILITY AMOUNT.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

137	CARRIER DENIED COVERAGE.	N598	HEALTH CARE POLICY COVERAGE IS PRIMARY.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
138	THE CLAIM DATE OF SERVICE OVERLAPS MULTIPLE RATES ON FILE FOR THIS PROVIDER.	N62	DATES OF SERVICE SPAN MULTIPLE RATE PERIODS. RESUBMIT SEPARATE CLAIMS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
139	THE DAYS SUPPLY IS MISSING OR INVALID.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
140	THE DAYS SUPPLY FOR THE DRUG DISPENSED IS MORE THAN THE MAXIMUM DAYS SUPPLY ALLOWED FOR THE NDC OR THE DAYS SUPPLY IS ZERO.	N378	MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
141	THE NDC IS NOT A VALID NDC FOR IOWA MEDICAID BILLING.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
142	THE 1ST PROCEDURE CODE MODIFIER IS NOT VALID WITH THE PROCEDURE CODE BILLED.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

143	THE 2ND PROCEDURE CODE MODIFIER IS NOT VALID FOR THE PROCEDURE CODE BILLED.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
144	THE PROCEDURE BILLED IS NOT A VALID PROCEDURE FOR THIS PROVIDER TYPE.		...	8	THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
145	THE DIAGNOSIS AND PROCEDURE BILLED ARE NOT COMPATIBLE. THE DIAGNOSIS MUST REFLECT THE MEDICAL NEED FOR THE PROCEDURE BILLED.		...	11	THE DIAGNOSIS IS INCONSISTENT WITH THE PROCEDURE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
146	THE PROCEDURE BILLED IS LIMITED TO A SPECIALTY OTHER THAN THAT OF THE PROVIDER BILLING FOR THE SERVICE.	N95	THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE.	8	THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
147	THE PROCEDURE CODE BILLED IS NOT VALID FOR THE PROVIDER BILLING THE SERVICE.	N95	THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE.	8	THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
148	THERE IS A DATE SPAN, AND THE SUBMITTED CHARGES ARE NOT EVENLY DIVISIBLE BY THE UNITS OF SERVICE.	N345	DATE RANGE NOT VALID WITH UNITS SUBMITTED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
149	THE REFERRING PROVIDER NAME AND NUMBER ARE REQUIRED.	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

150	THE DIAGNOSIS INDICATES THIS IS A TRAUMA/ACCIDENT CLAIM.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
151	VACCINE CODES (90471 OR 90472) AND PROCEDURE 90700-90750 MUST BE BILLED TOGETHER (IOWA VACCINE REPLACEMENT PROGRAM)	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	B15	THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE ...
152	PROCEDURE CODE AND/OR MODIFIER SUBMITTED REQUIRE MANUAL PRICING. INSUFFICIENT DATA WAS PROVIDED TO ALLOW A PRICING DETERMINATION.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
153	RECHECK CODING AND UNITS. THERE IS A DESCREPANCY BETWEEN THE CODE BILLED, THE CHARGE BILLED AND THE UNITS OF SERVICE BILLED.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
154	THE TPL DATA INDICATOR IS NOT A VALID VALUE. THE VALID VALUES ARE "Y", "N", OR SPACE.	N245	INCOMPLETE/INVALID PLAN INFORMATION FOR OTHER INSURANCE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
155	THE MAXIMUM NUMBER OF SERVICES ALLOWED PER CALENDAR MONTH HAS BEEN EXCEEDED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED

156	TREATING PROVIDER NUMBER IS MISSING, INVALID OR NOT A PART OF THE BILLING GROUP.	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
157	A PROVIDER PAYMENT RATE WAS NOT FOUND FOR THE DATE OF SERVICE. PLEASE CONTACT PROVIDER SERVICES FOR ASSISTANCE.	N65	PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF SERVICE/PROVIDER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
158	THE TREATING PROVIDER NUMBER IS NOT A VALID MEDICAID BILLING NUMBER.	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
159	THE NUMBER OF UNITS BILLED DO NOT EQUAL THE FROM THRU DAYS ON THE CLAIM.	N345	DATE RANGE NOT VALID WITH UNITS SUBMITTED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
160	THIS SERVICE REQUIRES A REFERRING PROVIDER NUMBER. THE REFERRING PROVIDER CANNOT BE THE TREATING PROVIDER.	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
161	AN INDEPENDENT LAB PROVIDER IS BILLING, AND THE PLACE OF SERVICE CODE IS NOT "81" INDICATING THE SERVICE WAS PERFORMED AT AN INDEPENDENT LAB.	M77	MISSING/INCOMPLETE/INVALID/INAPPROPRIATE PLACE OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

162	FROM/THROUGH DATES CANNOT BE USED FOR THIS PROCEDURE; IF MULTIPLE UNITS ARE BILLED, THEY MUST BE ON SEPARATE LINES.	N63	REBILL SERVICES ON SEPARATE CLAIM LINES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
163	THE TREATING PROVIDER IS A "GROUP." BOTH A GROUP NUMBER AND A TREATING PROVIDER NUMBER MUST BE SHOWN IN THE CORRECT FIELDS.	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
164	THE TREATING PROVIDER IS INELIGIBLE FOR THE DATES OF SERVICE.	N570	MISSING/INCOMPLETE/INVALID CREDENTIALING DATA.	B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
165	ALLOWANCE FOR SURGICAL TRAY HAS BEEN ADDED		...	70	COST OUTLIER - ADJUSTMENT TO COMPENSATE FOR ADDITIONAL COSTS
166	THE BILLING PROVIDER IS INELIGIBLE FOR THE DATES OF SERVICE.	N257	MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
167	A TREATING PROVIDER NUMBER IS ON THE CLAIM AND THE BILLING PROVIDER NUMBER IS NOT A GROUP.	N55	PROCEDURES FOR BILLING WITH GROUP/REFERRING/PERFORMING PROVIDERS WERE NOT FOLLOWED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

168	THE PROCEDURE CODE IS NOT A VALID CODE FOR IOWA MEDICAID BILLING.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
169	THE PROCEDURE OR REVENUE CODE IS NOT COVERED BY IOWA MEDICAID.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
170	THE PLACE OF SERVICE CODE IS MISSING OR INVALID.	M77	MISSING/INCOMPLETE/INVALID/INAPPROPRIATE PLACE OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
171	MISSING/INCOMPLETE/INVALID CLIA CERTIFICATION NUMBER OR IT IS NOT WITHIN AN EFFECTIVE CLIA DATE RANGE FOR THE LABORATORY SERVICE BILLED.	MA120	MISSING/INCOMPLETE/INVALID CLIA CERTIFICATION NUMBER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
172	THE RECIPIENT'S AGE IS NOT WITHIN THE AGE RANGE ALLOWED FOR THE PROCEDURE CODE.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
173	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE PROCEDURE CODE.		...	7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
174	THE SERVICE BILLED IS NOT COVERED FOR THIS RECIPIENT. THE RECIPIENT HAS LIMITED COVERAGE FOR EMERGENCY CARE ONLY.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	27	EXPENSES INCURRED AFTER COVERAGE TERMINATED

175	THE PROCEDURE CODE OR MODIFIER BILLED IS EITHER INVALID, MISSING OR NONPAYABLE FOR THE DATE OF SERVICE.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
176	THE REVENUE CODE BILLED IS NOT A VALID REVENUE CODE FOR IOWA MEDICAID.	M50	MISSING/INCOMPLETE/INVALID REVENUE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
177	THE PROCEDURE/SERVICE BILLED HAS BEEN DETERMINED TO BE NONCOVERED FOR THE DATE OF SERVICE SHOWN ON THE CLAIM.	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
178	THE RECIPIENT IS ENROLLED IN A MEDICAID HMO/MCO. THE SERVICE/DATE IS NOT COVERED UNDER FEE-FOR-SERVICE MEDICAID - THE HMO/MCO MUST BE BILLED.		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
179	THE UNITS OF SERVICE ARE EQUAL TO ZERO FOR THE REVENUE CODES 100-219. ROMM AND BOARD UNITS ARE REQUIRED TO SHOW THE NUMBER OF DAYS.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
180	THE PROCEDURE CODE IS FOR EPSDT SERVICES AND THE RECIPIENT IS 21 OR OLDER. RECIPIENTS OVER AGE 21 ARE NOT ELIGIBLE FOR EPSDT SERVICES.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
181	THE FIRST DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS FOR IOWA MEDICAID.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

182	THE FIRST DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
183	THE DIAGNOSIS BILLED REQUIRES AN ATTACHMENT: STERILIZATION CONSENT FORM, ABORTION CERTIFICATION, HYSTERECTOMY STATEMENT.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
184	INVALID MODIFIER CODE FOR AN INDEPENDENT LAB PROCEDURE. PLEASE CORRECT AND RESUBMIT CLAIM.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
185	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FIRST DIAGNOSIS CODE.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
186	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FIRST DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
187	THE DRUG IS LESS THAN EFFECTIVE OR WITHDRAWN FROM THE MARKET.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
188	THE SECOND DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS FOR IOWA MEDICAID.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

189	THE SECOND DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
190	THE DIAGNOSIS BILLED REQUIRES AN ATTACHMENT: STERILIZATION CONSENT FORM, ABORTION CERTIFICATION OR HYSTERECTOMY STATEMENT.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
191	THE RECIPIENT'S DATE OF DEATH IS BEFORE THE LAST DATE OF SERVICE.		...	13	THE DATE OF DEATH PRECEDES THE DATE OF SERVICE
192	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE SECOND DIAGNOSIS CODE.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
193	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SECOND DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
194	PROCEDURE REQUIRES SUPPORTING DOCUMENTATION INCLUDING IDENTIFICATION OF PROCEDURE/SERVICE AND MEDICAL NECESSITY.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
195	PAY-TO PROVIDER HAS NOT ATTESTED.	N570	MISSING/INCOMPLETE/INVALID CREDENTIALING DATA.	B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
196	THE THIRD DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

197	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
198	PROCEDURE REQUIRES MEDICAL REVIEW FOR THE DATE OF SERVICE ENTERED. DOCUMENTATION WAS NOT SUFFICIENT TO DETERMINE MEDICAL NECESSITY.	N661	DOCUMENTATION DOES NOT SUPPORT THAT THE SERVICES RENDERED WERE MEDICALLY NECESSARY.	50	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
199	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE THIRD DIAGNOSIS CODE.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
200	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE THIRD DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
201	PROVIDER IS INELIGIBLE FOR THE WAIVER TYPE ON CLAIM, PLEASE CORRECT AND RESUBMIT.	N95	THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE.	170	PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
202	THE FOURTH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
203	THE FOURTH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

204	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
205	PROCEDURE NOT APPLICABLE TO APG REIMBURSEMENT. THE GROUPER HAS DENIED THE PROCEDURE BILLED AS NOT APPLICABLE. VERIFY PROCEDURE CODING.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
206	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FOURTH DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
207	TRANSACTION SUBMITTED FOR A CREDITED OR DENIED CLAIM, PLEASE RESUBMIT.	N547	A REFUND REQUEST (FREQUENCY TYPE CODE 8) WAS PROCESSED PREVIOUSLY.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
208	THE 2ND DIAGNOSIS BILLED REQUIRES MEDICAL REVIEW. DOCUMENTATION PROVIDED DID NOT ESTABLISH MEDICAL NECESSITY.	N661	DOCUMENTATION DOES NOT SUPPORT THAT THE SERVICES RENDERED WERE MEDICALLY NECESSARY.	50	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
209	THE PLACE OF SERVICE BILLED IS NOT A VALID PLACE OF SERVICE FOR PHYSICIAN ASSISTANT SERVICES.	M77	MISSING/INCOMPLETE/INVALID/INAPPROPRIATE PLACE OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
210	THE FIFTH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

211	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
212	THE 3RD DIAGNOSIS CODE REQUIRES MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
213	DUPLICATE CASE MANAGEMENT SERVICES WERE RECEIVED FOR THE CALENDAR MONTH.		...	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
214	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FIFTH DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
215	THE 4TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
216	THE SIXTH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
217	THE SIXTH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

218	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
219	THE 5TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
220	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE SIXTH DIAGNOSIS CODE.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
221	THE RECIPIENT IS A QUALIFIED MEDICARE BENEFICIARY AND IS ELIGIBLE ONLY FOR PAYMENT OF COINSURANCE AND DECUTIBLES ON MEDICARE COVERED SERVICES.	N479	MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
222	THE 6TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
223	RECIPIENT IS NOT ELIGIBLE FOR THE WAIVER TYPE BILLED FOR THE CLAIM DATES OF SERVICE OR THE WAIVER TYPE IS MISSING OR INVALID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
224	A VALID MODIFIER FOR CRNA SERVICES WAS NOT BILLED.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

225	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
226	THE 7TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
227	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE SEVENTH DIAGNOSIS CODE.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
228	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SEVENTH DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
229	THE PRIOR AUTHORIZATION REASON CODE IS MISSING OR NOT ON FILE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	197	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT ABSENT
230	THE SERVICE/ITEM BILLED REQUIRES PRIOR AUTHORIZATION. THERE IS NO PRIOR AUTHORIZATION FOR ALL OR PART OF THIS DATE SPAN BILLED.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	197	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT ABSENT
231	INVALID OR MISSING PATIENT MANAGER REFERRAL NUMBER FOR THIS RECIPIENT.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	197	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT ABSENT
232	THE PROCEDURE CODE REQUIRES A PRIOR AUTHORIZATION NUMBER AND THE RECIP- IENT ON THE CLAIM DOES MATCH THE RECIPIENT ID ON THE PA.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	284	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES
233	THE PROCEDURE CODE REQUIRES A PRIOR AUTHORIZATION NUMBER AND THE MODIFIER ON THE CLAIM DOES NOT MATCH THE MODIFIER ON THE PA.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	284	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES
234	PROVIDER CANNOT MEDICALLY DIRECT A CRNA.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	197	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT ABSENT

235	THE LEVEL OF CARE INDICATOR IS MISSING OR INVALID.	N188	THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
236	HOSPICE REVENUE CODE NUMBER OF HOURS (UNITS) IS BELOW THE REQUIRED 8 HOURS OF SERVICE PER DAY.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
237	THE PROCEDURE CODE REQUIRES A PRIOR AUTHORIZATION AND THE PROCE- DURE CODE ON THE CLAIM DOES NOT MATCH THE PROCEDURE CODE ON THE PA.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	284	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES
238	THIS SERVICE/ITEM REQUIRED A PRIOR AUTHORIZATION. THE DATE OF SERVICE ON THE CLAIM ARE NOT WITHIN THE DATE RANGE OF THE PRIOR AUTHORIZATION.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	284	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES
239	THE PROCEDURE CODE REQUIRES A PRIOR AUTHORIZATION NUMBER AND THE LINE ITEM ON THE CLAIM IS NOT APPROVED.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	39	SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED
240	RECIPIENT ELIGIBIITY RECORD DOES NOT SHOW THE BILLING PROVIDER AS THE CORRECT PROVIDER FOR THE DATE OF SERVICE ON THE CLAIM. CONTACT DHS.	N54	CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
241	THE PRIOR AUTHORIZATION HAS BEEN USED.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	198	PRECERTIFICATION/NOTIFICATION/AUTHORIZATION/PRE-TREATMENT EXCEEDED
242	THE RECIPIENT IS 65 OR OLDER AND NO MEDICARE COVERAGE IS PRESENT ON THE RECIPIENT FILE.	N479	MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

243	IOWA MEDICAID HAS NOT ESTABLISHED A FEE FOR THIS PROCEDURE AND THE ALLOWED AMOUNT ON THE PRIOR AUTHORIZATION IS ZERO.	N65	PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF SERVICE/PROVIDER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
244	THE 8TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
245	THE COVERED DAYS BILLED WERE REDUCED TO THE NUMBER OF DAYS OF MEDICAID ELIGIBILITY.		...	239	CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE. REBILL SEPARATE CLAIMS
246	THE RECIPIENT WAS NOT ELIGIBLE FOR MEDICAID FOR THE ENTIRE DATE SPAN BILLED.		...	239	CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE. REBILL SEPARATE CLAIMS
247	RECIPIENT GUARDIAN INFORMATION IS NOT ON RECIPIENT FILE FOR DOS. PLEASE CONTACT LOCAL COUNTY OFFICE TO VERIFY GUARDIAN INFORMATION.	N77	MISSING/INCOMPLETE/INVALID DESIGNATED PROVIDER NUMBER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
248	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
249	MORE THAN 20 CLAIMS HAVE BEEN SUBMITTED FOR THIS RECIPIENT, CLAIMS WILL BE PROCEESSED IN THE NEXT CYCLE.		...	133	THE DISPOSITION OF THIS SERVICE LINE IS PENDING FURTHER REVIEW. (USE ONLY WITH GROUP CODE OA). USAGE: USE OF THIS CODE REQUIRES A REVERSAL AND CORRECTION WHEN THE SERVICE LINE IS FINALIZED (USE ONLY IN LOOP 2110 CAS SEGMENT OF THE 835 OR LOOP 2430 OF ...
250	DRG IS NOT VALID FOR THE DATES OF SERVICE ON CLAIM. TYPE OF BILL OR DIAGNOSIS/PROCEDURE CODE(S) MAY BE INVALID.		...	A8	UNGROUPABLE DRG

251	THE RECIPIENT NUMBER IS NOT ON THE ELIGIBILITY FILE. VERIFY CORRECT RECIPIENT ID NUMBER AND RESUBMIT CLAIM WITH VALID NUMBER.		...	31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED
252	THE DHS ELIGIBILITY RECORD IS NOT SHOWING APPROVAL FOR THIS FACILITY FOR THIS DATE OF SERVICE.	N188	THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
253	THE NINTH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
254	THE NINTH DIAGNOSIS CODE IS NOT COVERED BY MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
255	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
256	THE RECIPIENT HAS MEDICARE COVERAGE ACCORDING TO DHS RECORDS. MEDICARE MUST BE BILLED FOR THE SERVICE. MEDICAID WILL PAY CROSS-OVER CLAIM ONLY	N479	MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
257	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE NINTH DIAGNOSIS CODE.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

258	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE NINTH DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
259	THE SERVICE IS NOT COVERED FOR IOWA HEALTH AND WELLNESS PLAN MEMBERS. HMO/MARKETPLACE MUST BE BILLED FOR MEMBERS ASSIGNED TO THEM.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	109	CLAIM/SERVICE NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 | LAST MODIFIED: 01/29/2012...
260	THE FIRST SURGICAL PROCEDURE CODE IS NOT A VALID CODE FOR MEDICAID.	MA66	MISSING/INCOMPLETE/INVALID PRINCIPAL PROCEDURE CODE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
261	THE FIRST SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
262	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
263	ABORTIONS, STERILIZATIONS, AND HYSTERECTOMIES MUST BE SUBMITTED WITH PROPER DOCUMENTATION FOR MANUAL REVIEW.	N66	MISSING/INCOMPLETE/INVALID DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
264	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FIRST SURGICAL PROCEDURE CODE.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

265	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FIRST SURGICAL PROCEDURE CODE.		...	7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
266	THE FIRST SURGICAL PROCEDURE CODE REQUIRES PRIOR AUTHORIZATION AND THE PRIOR AUTHORIZATION NUMBER IS ZEROES.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	284	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES
267	THE SECOND SURGICAL PROCEDURE CODE IS NOT ON THE PROCEDURE FILE.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
268	THE SECOND SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
269	TOTAL UNITS FOR REVENUE CODES 655 AND 658 EXCEED THE TOTAL NUMBER OF DAYS BILLED ON THE CLAIM FORM.	N345	DATE RANGE NOT VALID WITH UNITS SUBMITTED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
270	THE RECIPIENT IS NOT ELIGIBLE FOR MEDICAID ON THE DATE OF SERVICE BILLED	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	26	EXPENSES INCURRED PRIOR TO COVERAGE
271	THE RECIPIENT IS INELIGIBLE FOR THE DATE OF SERVICE. THE CLAIM WILL PEND TEMPORARILY TO ALLOW FOR ELIGIBILITY FILE UPDATES FROM DHS.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	26	EXPENSES INCURRED PRIOR TO COVERAGE
272	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SECOND SURGICAL PROCEDURE CODE.		...	7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

273	THE RECIPIENT IS NOT ELIGIBLE FOR MEDICAID ON EITHER ALL OR A PORTION OF THE DATES OF SERVICE BILLED.		...	238	CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE, THIS IS THE REDUCTION FOR THE INELIGIBLE PERIOD. (USE ONLY WITH GROUP CODE PR
274	THE THIRD SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
275	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
276	THE TOOTH NUMBER OR LETTER IS INVALID. PLEASE CORRECT AND RESUBMIT THE CLAIM.	N37	MISSING/INCOMPLETE/INVALID TOOTH NUMBER/LETTER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
277	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE THIRD SURGICAL PROCEDURE CODE.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
278	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE THIRD SURGICAL PROCEDURE CODE.		...	7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
279	THE FOURTH SURGICAL PROCEDURE CODE IS NOT ON THE PROCEDURE FILE.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

280	THE FOURTH SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
281	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
282	THERE IS AN ADJUSMENT IN PROCESS FOR THIS CLAIM.	N522	DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM.	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
283	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FOURTH SURGICAL PROCEDURE CODE.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
284	DUPLICATE OF A CLAIM PREVIOUSLY USED TO MEET MEDICALLY NEEDY SPENDDOWN.	N522	DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM.	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
285	THE FIFTH SURGICAL PROCEDURE CODE IS NOT ON THE PROCEDURE FILE.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
286	THE FIFTH SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

287	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
288	DHS RECORDS DO NOT SHOW A MATCHING NURSING FACILITY RECORD FOR THE FULL DATE RANGE.THIS RECORD MUST BE PRESENT FOR CLAIM PAYMENT TO BE MADE.	N54	CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
289	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FIFTH SURGICAL PROCEDURE CODE.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
290	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FIFTH SURGICAL PROCEDURE CODE.		...	7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
291	THE ADMIT DATE CONFLICTS WITH THE DATE OF SERVICE.	MA40	MISSING/INCOMPLETE/INVALID ADMISSION DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
292	THE SIXTH SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
293	THIS SERVICE IS AN EXACT DUPLICATE OF A SERVICE USED TO MEET MEDICALLY NEEDY SPEND DOWN. THESE CHARGES ARE THE LIABILITY OF THE RECIPIENT.	N522	DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM.	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO

294	THE DISCHARGE STATUS IS NOT VALID FOR THE TYPE OF CLAIM BILLED.	N50	MISSING/INCOMPLETE/INVALID DISCHARGE INFORMATION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
295	THIS SERVICE REPRESENTS A DUPLICATION OR OVERLAP OF SERVICES PROVIDED BY THE SAME OR A DIFFERENT PROVIDER THAT WAS APPLIED TOWARDS SPENDDOWN.	N522	DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM.	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
296	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SIXTH SURGICAL PROCEDURE CODE.		...	7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
297	CLAIM DOES NOT MEET MEDICAID PROVIDER MANUAL CRITERIA. CLAIM CAN BE RESUBMITTED IF ADDITIONAL DOCUMENTATION OF MEDICAL NECESSITY IS PROVIDED	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
298	UNLISTED CODES REQUIRE REPORT ATTACHED TO CLAIM EXPLAINING WHAT SERVICE WAS PROVIDED. PLEASE BE SURE CORRECT CODE WAS BILLED.	N350	MISSING/INCOMPLETE/INVALID DESCRIPTION OF SERVICE FOR A NOT OTHERWISE CLASSIFIED (NOC) CODE OR FOR AN UNLISTED/BY REPORT PROCEDURE.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
299	THE PRESCRIBING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE DME UNDER IOWA MEDICAID POLICY.		...	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
300	THIS SVC CANNOT BE BILLED BY THIS PROV TYPE ON THIS CLM FORM FOR THIS DATE OF SVC.(IHS,CHECK IF MEMB IS NOT NATIVE AMERICAN INDIAN)	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
301	THE DAYS SUPPLIED EXCEEDS THE MAXIMUM ALLOWED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED

302	ONLY ONE CHARGE CAN BE BILLED PER MONTH FOR EACH APPROVED SERVICE. ONE CHARGE MUST BE BILLED SHOWING ALL UNITS FOR THE MONTH.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
303	THE "E" DIAGNOSIS CODE CANNOT BE BILLED AS A PRIMARY DIAGNOSIS ON THE UB 04 CLAIM FORM. "E" DIAGNOSIS CODES CANNOT BE USED ON THE HCFA 1500.	MA63	MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
304	YOUR LICENSE HAS EXPIRED. PLEASE SEND COPY OF CURRENT RENEWAL.	M143	THE PROVIDER MUST UPDATE LICENSE INFORMATION WITH THE PAYER.	170	PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
305	THE LAST X-RAY DATE IS TOO OLD. THE MEDICAID PROVIDER MANUAL LISTS MEDICAID X-RAY REQUIREMENTS.	M1	X-RAY NOT TAKEN WITHIN THE PAST 12 MONTHS OR NEAR ENOUGH TO THE START OF TREATMENT.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
306	THE ACCIDENT DATE IS NOT VALID. PLEASE CORRECT AND RESUBMIT THE CLAIM.	N305	MISSING/INCOMPLETE/INVALID INJURY/ACCIDENT DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
307	A MINIMUM OF 8 HOURS PER DAY MUST BE BILLED.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

308	MEDICAL VISITS CANNOT BE BILLED SEPARATELY FROM A MAJOR SURGICAL PROCEDURE. THIS IS CONSIDERED NORMAL PRE/POST OPERATIVE CARE.	M144	PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
309	DRG NOT ON FILE.		...	A8	UNGROUPABLE DRG
310	THE ADJUSTMENT TCN DATE IS OVER 365 DAYS FROM THE ORIGINAL PAID DATE OF THE CLAIM TO BE ADJUSTED/CREDITED.		...	29	THE TIME LIMIT FOR FILING HAS EXPIRED
311	CROSSOVER CLAIM RECEIVED WITH NO MEDICARE ALLOWED AMOUNT, DEDUCTIBLE, AND COINSURANCE AMOUNT. PLEASE SUBMIT UB04 FOR PAYMENT CONSIDERATION.	N58	MISSING/INCOMPLETE/INVALID PATIENT LIABILITY AMOUNT.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
312	UNITS EXCEEDED MAXIMUM UNITS ALLOWED FOR PARTIAL HOSPITAL.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
313	UNITS SUBMITTED EXCEED THE MAXIMUM UNITS ALLOWED FOR DAY TREATMENT.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
314	DIAGNOSIS INDICATES SUBSTANCE ABUSE. THE SERVICE SHOULD BE BILLED TO THE SUBSTANCE ABUSE CONTRACTOR.		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
315	CASE MANAGEMENT SERVICES ARE PAYABLE BY MENTAL HEALTH CONTRACTOR FOR THIS RECIPIENT.		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
316	NO APG WEIGHT ASSIGNED FOR PROCEDURE BILLED.	N65	PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF SERVICE/PROVIDER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
317	COVERED DAYS ARE MISSING OR INVALID.	MA32	MISSING/INCOMPLETE/INVALID NUMBER OF COVERED DAYS DURING THE BILLING PERIOD.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

318	RECHECK ACCIDENT/SERVICE DATE. ACCIDENT DATE IS SHOWN AFTER THE DATE OF SERVICE OR IS AN INVALID DATE.	N305	MISSING/INCOMPLETE/INVALID INJURY/ACCIDENT DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
319	INVALID LEVEL OF CARE, PLEASE CORRECT AND RESUBMIT CLAIM.	N188	THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
320	THE CONDITION CODE BILLED IS NOT A VALID CONDITION CODE PER UB 04 MANUAL.	M44	MISSING/INCOMPLETE/INVALID CONDITION CODE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
321	PHARMACY CHARGES MUST BE BILLED ON THE UNIVERSL PHARMACY CLAIM FORM. TAKE-HOME SUPPLIES MUST BE BILLED ON A HCFA 1500 CLAIM.	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
322	SUPPLY/EQUIPMENT CHARGES MUST BE BILLED ON THE HCFA 1500 CLAIM FORM UNDER A DEALER PROVIDER NUMBER.	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
323	THE BILLING PROVIDER IS NOT CERTIFIED TO PROVIDE THE SERVICE BEING SUBMITTED.	N570	MISSING/INCOMPLETE/INVALID CREDENTIALING DATA.	B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

324	MULTIPLE OUTPATIENT SERVICES WITHIN 72 HOURS FOR A RELATED CONDITION MUST BE SUBMITTED ON THE SAME CLAIM. A PREVIOUS CLAIM HAS BEEN PAID.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
325	CANNOT PROCESS THIS CLAIM BECAUSE OF TOO MANY ERRORS. CONTACT THE PROVIDER RELATIONS DEPARTMENT FOR ASSISTANCE.		...	95	PLAN PROCEDURES NOT FOLLOWED
326	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE EIGHTH DIAGNOSIS CODE.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
327	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE SECOND SURGICAL PROCEDURE CODE.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
328	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE EIGHTH DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
329	TRANSACTION SUBMITTED WITH UNIDENTIFIABLE ELEMENTS OR NOT WITHIN ONE YEAR OF PAID DATE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
330	THE LINE ITEM DATE OF SERVICE IS NOT WITHIN THE COVERED DATES. CORRECT THE DATE OF SERVICE AND RESUBMIT.	N301	MISSING/INCOMPLETE/INVALID PROCEDURE DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
331	THE CLAIM DATE OF SERVICE IS TOO OLD TO PROCESS. TIMELY FILING GUIDELINES WERE NOT MET.		...	29	THE TIME LIMIT FOR FILING HAS EXPIRED

332	THIS IS NOT A PROCEDURE ON THE APPROVED LIST OF ASC SURGICAL SERVICES.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
333	AN OUTPATIENT CLAIM CANNOT BE BILLED WITHIN 72 HOURS OF AN INPATIENT CLAIM FROM THE SAME FACILITY. CHARGES MUST BE COMBINED.		...	60	CHARGES FOR OUTPATIENT SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN A PERIOD OF TIME PRIOR TO OR AFTER INPATIENT SERVICES
334	PROVIDER IS INELIGIBLE TO BILL FOR SPECIAL CHILD ABUSE PROCEDURE CODES.	N570	MISSING/INCOMPLETE/INVALID CREDENTIALING DATA.	B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
335	THE CLAIM EXCEEDS THE LINE ITEM THRESHOLD ALLOWED BY MEDICAID.	N61	REBILL SERVICES ON SEPARATE CLAIMS.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
336	THE "E" DIAGNOSIS CODE CANNOT BE USED AS THE PRIMARY DIAGNOSIS.	MA63	MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
337	INVALID PROCEDURE CODE FOR APG GROUPER - THE GROUPER DID NOT ACCEPT THE PROCEDURE CODE BILLED AS A VALID OUTPATIENT CODE FOR THIS DATE.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

338	A CHARGE CANNOT BE SUBMITTED FOR BOTH A PANORAMIC X-RAY AND A COMPLETE INTRA-ORAL SERIES.	N20	SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
339	ADJUSTMENT SUBMITTED ON A DENIED CLAIM. PLEASE RESUBMIT AS A NEW CLAIM.	N142	THE ORIGINAL CLAIM WAS DENIED. RESUBMIT A NEW CLAIM, NOT A REPLACEMENT CLAIM.	A1	CLAIM/SERVICE DENIED. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.
340	PRESCRIBING/ORDERING/REFERRING PROVIDER NOT ENROLLED WITH IOWA MEDICAID AS REQUIRED BY THE AFFORDABLE CARE ACT.		...	183	THE REFERRING PROVIDER IS NOT ELIGIBLE TO REFER THE SERVICE BILLED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
341	AN INVALID LEVEL OF CARE OR TERMINATION CODE WAS BILLED BASED ON THE FACILITY RECORD OF THE RECIPIENT.	N188	THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
342	MULTIPLE OP PROCEDURES PERFORMED WITHIN 72 HOURS SHOULD BE SUBMITTED ON THE SAME CLAIM FORM.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
343	CLAIM SUBMITTED AS A CROSSOVER. MEMBER DOES NOT HAVE MEDICARE.	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
344	THE MAXIMUM NUMBER OF STRESS TESTS ALLOWED HAS BEEN EXCEEDED. IF UNUSUAL CIRCUMSTANCES ARE DOCUMENTED, MEDICAL REVIEW CAN BE REQUESTED.	N435	EXCEEDS NUMBER/FREQUENCY APPROVED /ALLOWED WITHIN TIME PERIOD WITHOUT SUPPORT DOCUMENTATION.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED

345	MEMBER IS NOT CERTIFIED FOR HOSPICE SERVICE	M46	MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
346	REV CODE 001 MUST BE SUBMITTED ON LINE 23 OF UB04	M50	MISSING/INCOMPLETE/INVALID REVENUE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
347	THE REVENUE CODE BILLED IS NOT A VALID REVENUE CODE AS SHOWN IN THE UB04 BILLING MANUAL OR THE REVEUNE CODE IS NOT ALLOWED FOR PROVIDER TYPE.	M50	MISSING/INCOMPLETE/INVALID REVENUE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
348	CLAIM SHOWS CONFLICTING MEDICARE EXHAUST DATE WITH BILLNG DATE.	MA31	MISSING/INCOMPLETE/INVALID BEGINNING AND ENDING DATES OF THE PERIOD BILLED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
349	THE SERVICE LIMIT FOR THIS ITEM OR SERVICE HAS BEEN EXCEEDED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
350	CLAIM DENIED. THE SYSTEM CALCULATED A NUMBER THAT IS TOO LARGE FOR THE FIELD WHICH IS BEING CALCULATED. PLEASE VERIFY YOUR UNITS AND RESUBMIT.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
351	PROCEDURE CODE, REV CODE, DIAGNOSIS COMBINATION IS NOT COVERED FOR MEMBER.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	256	SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT

352	CONTINUOUS HOME CARE MUST BE PROVIDED WITH A MINIMUM OF 8 HOURS PER DAY.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
353	THE PROCEDURE CODE BILLED IS NOT A VALID PROCEDURE CODE FOR IA MEDICAID OR FOR FQHC/RHC/IHS T1015/D9999 IS NOT BILLED ON THE FIRST LINE.	N95	THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE.	8	THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
354	THE RECIPIENT IS NOT ELIGIBLE FOR TARGETED CASE MANAGEMENT SERVICES BASED ON RECORDS PROVIDED BY DHS.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
355	RECIPIENT IS LOCKED IN TO A SPECIFIC PROVIDER. THE PROVIDER BILLING IS NOT THE LOCK-IN PROVIDER.	N450	COVERED ONLY WHEN PERFORMED BY THE PRIMARY TREATING PHYSICIAN OR THE DESIGNEE.	242	SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS
356	NO DRUG PRICING SEGMENT FOR THE DATE OF SERVICE OR OBSOLETE DRUG	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
357	YOU HAVE BILLED A DATE SPAN THAT INDICATES A RENTAL, BUT YOU DID NOT BILL WITH THE RENTAL MODIFIER (RR). PLEASE CORRECT CLAIM AND RESUBMIT.		...	108	RENT/PURCHASE GUIDELINES WERE NOT MET. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
358	THE SERVICE IS NOT COVERED FOR MARKETPLACE MEMBERS. HMO/MARKETPLACE MUST BE BILLED FOR MEMBERS ASSIGNED TO THEM.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	109	CLAIM/SERVICE NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 | LAST MODIFIED: 01/29/2012...

359	MISSING OR INCOMPLETE DOCUMENTATION	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
360	THERE IS A CONFLICT BETWEEN THE DATES OF SERVICE BILLED AND THE UNITS OF SERVICE BILLED.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
361	SERVICE LIMIT EXCEEDED FOR BILLED SERVICE.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
362	MULTIPLE DENTAL EXAMS HAVE BEEN BILLED FOR THIS RECIPIENT ON THIS DATE. THIS IS PAYABLE ONLY IF EACH DENTIST HAS A DIFFERENT SPECIALTY.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	B14	ONLY ONE VISIT OR CONSULTATION PER PHYSICIAN PER DAY IS COVERED
363	DENTAL CONSULTATIONS ARE LIMITED TO 1 PER YEAR FOR EACH RECIPIENT. ADDITIONAL CONSULTATIONS MUST BE BILLED AS AN EVALUATION.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
364	EMERGENCY ORAL EXAM CANNOT BE BILLED WITH TREATMENT. CODE D0140/00140 CANNOT BE BILLED IN ADDITION TO OTHER TREATMENT SERVICCES.	N20	SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
365	THE PROCEDURE CODE CANNOT BE PERFORMED IN THE PLACE OF SERVICE BILLED UNDER IOWA MEDICAID POLICY.	N428	NOT COVERED WHEN PERFORMED IN THIS PLACE OF SERVICE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

366	CLAIMS ARE REQUIRED TO BE FILED ELECTRONICALLY.	M117	NOT COVERED UNLESS SUBMITTED VIA ELECTRONIC CLAIM.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
367	THE SERVICE LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. IF PROSTHETIC WAS LOST, STOLEN, OR BROKEN BEYOND REPAIR, THIS MUST BE DOCUCMENTED.		...	273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
368	CLAIM DATE OF SERVICE EXCEEDS TIMELY FILING LIMITS.		...	29	THE TIME LIMIT FOR FILING HAS EXPIRED
369	NO GUARDIAN RECORD ON FILE.	MA75	MISSING/INCOMPLETE/INVALID PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
370	OXYGEN HAS BEEN PREVIOUSLY BILLED FOR THE SAME OR OVERLAPPING SERVICE DATES.		...	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
372	THIS BILLING EXCEEDS THE MAXIMUM ALLOWED FOR DME RENTAL - EITHER MULTIPLE RENTALS PER MONTH OR RENTAL EXCEEDS 100% OF PURCHASE PRICE.	N370	BILLING EXCEEDS THE RENTAL MONTHS COVERED/APPROVED BY THE PAYER.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
374	THE SERVICE BILLED ON THIS LINE REPRESENT A CHARGE NOT COVERED BY MEDICARE. COVERED SERVICES MUST BE BILLED ON A MEDICAID CLAIM.	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
376	THE RECIPIENT'S AGE IS OUTSIDE THE COVERED AGE RANGE FOR MENTAL HEALTH INSTITUTES.	N129	NOT ELIGIBLE DUE TO THE PATIENT'S AGE.	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

377	THE COVERED DAYS FOR PMIC OR MHI IS GREATER THAN 31 DAYS.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
380	A BITEWING X-RAY CANNOT BE BILLED SEPARATELY IN ADDITION TO A COMPLETE INTRA-ORAL SERIES.	M80	NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
381	THE MEDICARE ALLOWED AMOUNT IS ZERO. THE MEDICAID PAYABLE AMOUNT IS COINSURANCE AND DEDUCTIBLE ON MEDICARE COVERED SERVICES.	N480	INCOMPLETE/INVALID EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
382	MULTIPLE PROCEDURE PAYMENT REDUCTION APPLIED		...	59	PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES. (FOR EXAMPLE MULTIPLE SURGERY OR DIAGNOSTIC IMAGING, CONCURRENT ANESTHESIA.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PR...
383	POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON-COVERED CHARGES AND/OR NON-COVERED DAYS. REFER TO IL	MA33	MISSING/INCOMPLETE/INVALID NON-COVERED DAYS DURING THE BILLING PERIOD.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
384	MISSING/INCOMPLETE/INVALID PRESENT ON ADMISSION INDICATOR.	N434	MISSING/INCOMPLETE/INVALID PRESENT ON ADMISSION INDICATOR.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

385	THE MAXIMUM UNITS FOR FOR THIS ITEM HAS BEEN EXCEEDED.		...	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
388	THE WRONG CIRCUMCISION CODE WAS BILLED FOR A NEWBORN INFANT.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
389	THE RECIPIENT ID NUMBER ON THE CLAIM IS NOT ON FILE. CORRECT RECIPIENT ID NUMBER AND RESUBMIT YOUR CLAIM.		...	31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED
390	A REFRACTION AND AN EYE EXAM OR OTHER EVALUATION/MANAGEMENT SERVICE ARE NOT PAYABLE SEPARATELY ON THE SAME DATE OF SERVICE.	N20	SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
392	NO SUPPORTING LINES ARE PRESENT ON THE CLAIM TO SHOW WHICH SERVICES WERE RENDERED WHEN SUBMITTED BY FQHC/RHC/IHS.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
393	PROCEDURE/MAXIMUM UNITS CONFLICT. THE NUMBER OF UNITS BILLED EXCEEDS THE NUMBER OF UNITS ROUTINELY ALLOWED FOR THIS SERVICE.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
395	THE SERVICE BILLED REQUIRES MANUAL PRICING. PLEASE RESUBMIT A PAPER CLAIM WITH DOCUMENTATION ATTACHED.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
397	A RURAL/INDIAN HEALTH VISIT AND A PHYSICIAN VISIT ARE NOT PAYABLE ON THE SAME DATE BY PROVIDERS AT THE SAME FACILITY.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...

400	THE SERVICE LIMIT FOR THE ITEM OR SERVICE BILLED HAS BEEN EXCEEDED. THE MAXIMUM NUMBER OF UNITS ALLOWED HAS BEEN PREVIOUSLY PAID.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
401	THIS SERVICE IS COVERED BY IOWA PLAN.		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
402	THE EMPLOYMENT RELATED INDICATOR IS NOT "Y" OR "N". NO OTHER VALUES CAN BE SHOWN IN THIS FIELD.	MA90	MISSING/INCOMPLETE/INVALID EMPLOYMENT STATUS CODE FOR THE PRIMARY INSURED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
403	AN INVALID VALUE WAS USED FOR OTHER INSURANCE.	N245	INCOMPLETE/INVALID PLAN INFORMATION FOR OTHER INSURANCE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
404	FRAGMENTED LABORATORY SERVICES WERE BILLED. MULTIPLE UA'S OR MULTIPLE BLOOD COUNTS CANNOT BE BILLED ON THE SAME DATE OF SERVICE.	N20	SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
405	THE NUMBER OF UNITS ALLOWED FOR THIS SERVICE HAS BEEN EXCEEDED.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
407	THIS RECIPIENT IS COVERED BY AN HMO AND IOWA PLAN. IF THE SERVICE IS NOT COVERED BY THE IOWA PLAN, IT MUST BE BILLED TO THE MEDICAID HMO.		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
409	SERVICE IS PAYABLE FOR BINAURAL OR MONAURAL BUT NOT BOTH.	N20	SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
410	ONLY 1 HOUR OF CRITICAL CARE (CPT 99291) ALLOWED PER PROVIDER, PER RECIPIENT, PER DAY.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED

411	AFTER REVIEW OF PROVIDER AND SERVICES, IT WAS DETERMINED THAT THE BILLING DOES NOT MEET MEDICAID POLICY CRITERIA.	N35	PROGRAM INTEGRITY/UTILIZATION REVIEW DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
412	THE MAXIMUM MONTHLY ALLOWED AMOUNT FOR THE SERVICE BILLED AS BEEN EXCEEDED. ADDITIONAL PAYMENT CANNOT BE MADE.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
413	ANTEPARTUM, POSTPARTUM, OR DELIVERY CANNOT BE BILLED WITHIN NINE MONTHS BEFORE OR 45 DAYS AFTER TOTAL OB/C-SECTION CARE.	N357	TIME FRAME REQUIREMENTS BETWEEN THIS SERVICE/PROCEDURE/SUPPLY AND A RELATED SERVICE/PROCEDURE/SUPPLY HAVE NOT BEEN MET.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
414	FRAGMENTED SERVICES HAVE BEEN BILLED ON THIS DATE. THE DENIED SERVICE IS CONSIDERED PART OF THE PREVIOUSLY PAID MEDICAL SERVICE.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
416	THE LEAVE DAYS BILLED EXCEED THE MAXIMUM ALLOWED BY MEDICAID.	N43	BED HOLD OR LEAVE DAYS EXCEEDED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
417	THE LEAVE DAYS BILLED EXCEED THE MAXIMUM ALLOWED BY MEDICAID.	N43	BED HOLD OR LEAVE DAYS EXCEEDED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
418	ONLY ONE CHARGE FOR DELIVERY SERVICE CAN BE BILLED IN A NINE MONTH PERIOD. OB CARE HAS BEEN PREVIOUSLY PAID.	N357	TIME FRAME REQUIREMENTS BETWEEN THIS SERVICE/PROCEDURE/SUPPLY AND A RELATED SERVICE/PROCEDURE/SUPPLY HAVE NOT BEEN MET.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...

419	ONLY ONE COLLECTION/HANDLING FEE IS ALLOWED PER DATE OF SERVICE.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
420	THE LAB TESTS BILLED ARE CONSIDERED FRAGMENTED. THE REIMBURSEMENT FOR THIS TEST IS INCLUDED WITH OTHER LAB WORK PREVIOUSLY PAID.	M80	NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
421	MULTIPLE OR FRAGMENTED DENTAL VISITS WERE BILLED FOR THIS DATE OF SERVICE.	M80	NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
423	THE TREATING PROVIDER IS NOT A MEMBER OF THE GROUP THAT IS BILLING.	N55	PROCEDURES FOR BILLING WITH GROUP/REFERRING/PERFORMING PROVIDERS WERE NOT FOLLOWED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
424	NEW PATIENT VISIT NOT ALLOWED WITHIN THREE YEARS OF PREVIOUS NEW PATIENT VISIT BY SAME PROVIDER. AN ESTABLISHED PATIENT VISIT MUST BE BILLED.		...	B16	'NEW PATIENT' QUALIFICATIONS WERE NOT MET
425	HOME HEALTH SERVICE IS NOT INTERMITTENT AND DOES NOT MEET MEDICAID GUIDELINES.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
426	NON-PAYABLE APG AS DETERMINED BY THE APG GROUPER. SERVICE MAY PACKAGE WITH OTHER PAYABLE APGS IF PRESENT ON CLAIM.	M15	SEPARATELY BILLED SERVICES/TESTS HAVE BEEN BUNDLED AS THEY ARE CONSIDERED COMPONENTS OF THE SAME PROCEDURE. SEPARATE PAYMENT IS NOT ALLOWED.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
427	DIAGNOSTIC CASTS ARE PAYABLE ONLY WHEN THE CLAIM SPECIFIES THAT THEY ARE FOR ORTHODONTIA OR THAT THEY WERE REQUESTED BY THE CONSULTANT.		...	272	COVERAGE/PROGRAM GUIDELINES WERE NOT MET
428	THE MAXIMUM NUMBER OF SERVICE UNITS HAS BEEN EXCEEDED FOR A THREE- MONTH TIME PERIOD.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED

429	APG GROUPER EDIT - THE PROCEDURE BILLED IS DESIGNATED AS INPATIENT AND CANNOT BE BILLED ON AN OUTPATIENT CLAIM.	MA30	MISSING/INCOMPLETE/INVALID TYPE OF BILL.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
430	A SCREENING PHYSICAL INCLUDES A HEARING TEST; THEREFORE A HEARING TEST AND A SCREENING PHYSICAL CANNOT BE BILLED SEPARATELY.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
431	CODES 59425/59426 ARE ONLY PAYABLE ONCE PER PREGNANCY WHEN THE CLAIM DOCUMENTS THAT THIS DR./CLINC WILL NOT BE BILLING OB DELIVERY.	N525	THESE SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN THE GLOBAL PERIOD OF ANOTHER SERVICE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
432	THE CLAIM REQUIRES AN ATTACHMENT - THE HYSTERECTOMY STATEMENT, STERILIZATION CONSENT OR ABORTION CERTIFICATION IS MISSING/INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
433	FRAGMENTED SERVICES WERE BILLED ON THE SAME DATE OF SERVICE FOR THIS RECIPIENT.THIS IS PART OF A SERVICE PREVIOUSLY PAID.	M80	NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
434	OUTPATIENT MENTAL HEALTH TREATMENT LIMITATION HAS BEEN PHASED OUT BY MEDICARE. PLEASE REFER TO IL 1486.	N480	INCOMPLETE/INVALID EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

436	THE ELECTRONIC SUBMISSION INDICATES THAT AN ATTACHMENT WAS SUBMITTED; HOWEVER, NO RELATED ATTACHMENT COULD BE IDENTIFIED.		...	163	ATTACHMENT/OTHER DOCUMENTATION REFERENCED ON THE CLAIM WAS NOT RECEIVED
441	PROVIDER NOT ENROLLED FOR WAIVER TYPE BILLED.	N95	THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE.	8	THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
442	DME RENTAL FOR THIS ITEM HAS PREVIOUSLY BEEN PAID. ONLY ONE RENTAL IS PAYABLE PER MONTH.		...	B13	PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT
445	THIS EXCEPTION TO POLICY SERVICE IS PAYABLE WITH SPECIFIC TIME LIMITS. THE SERVICE HAS PREVIOUSLY BEEN PAID WITHIN THE TIME LIMIT ALLOWED.		...	B13	PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT
447	FIRST DIAGNOSIS CODE REQUIRES MEDICAL REVIEW. DOCUMENTATION OF MEDICAL NECESSITY MUST BE PROVIDED.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
448	A CIRCUMCISION HAS PREVIOUSLY BEEN BILLED FOR THIS RECIPIENT. ONLY ONE CIRCUMCISION IS PAYABLE.		...	B13	PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT
450	THIS DRUG WAS DISPENSED AFTER THE EXPIRATION DATE OF THE NDC #. PLEASE RESUBMIT WITH CORRECT NDC NUMBER.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
451	NO REIMBURSEMENT RATE IS PROVIDED FOR THIS DATE OF SERVICE; CHECK THE SERVICE DATE TO DETERMINE IF IS WAS BILLED CORRECTLY.	N65	PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF SERVICE/PROVIDER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

453	PHYSICAL THERAPY IS NOT PAID AS A SEPARATE BENEFIT FOR A RECIPIENT IN A NURSING HOME. IT IS INCLUDED IN THE NH PER DIEM.	M97	NOT PAID TO PRACTITIONER WHEN PROVIDED TO PATIENT IN THIS PLACE OF SERVICE. PAYMENT INCLUDED IN THE REIMBURSEMENT ISSUED THE FACILITY.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
455	ALLOWED ONLY ONCE PER YEAR AND ONLY ON PATIENT OWNED VENTILATOR.	M90	NOT COVERED MORE THAN ONCE IN A 12 MONTH PERIOD.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
458	MEDICAID WILL ONLY PAY FOR CROSS-OVERS WHEN THE MEDICARE PAYMENT PLUS COINSURANCE/DEDUCTIBLE IS LESS THAN THE MEDICAID FEE FOR THE SERVICE.		...	272	COVERAGE/PROGRAM GUIDELINES WERE NOT MET
460	THE DIAGNOSIS CODE IS NOT A VALID VALID ICD-9-CM DIAGNOSIS CODE.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
463	THE DIAGNOSIS IS MISSING OR INVALID FOR A DRG CLAIM. RESUBMIT WITH A DIAGNOSIS WARRANTING ACUTE INPATIENT CARE.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
465	OUR RECORDS INDICATE THAT THE RECIPIENT HAS A MEDICAL ASSISTANCE INCOME TRUST. THIS PAYMENT MUST BE ENTERED AS A 3RD PARTY PAYMENT ON THE CLAIM	MA92	MISSING PLAN INFORMATION FOR OTHER INSURANCE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
467	DME RENTAL ITEMS MUST HAVE AN "RR" MODIFIER.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

468	THIS CHARGES REPRESENTS A FRAGMENTATION OF OB ULTRASOUND SERVICES.	M15	SEPARATELY BILLED SERVICES/TESTS HAVE BEEN BUNDLED AS THEY ARE CONSIDERED COMPONENTS OF THE SAME PROCEDURE. SEPARATE PAYMENT IS NOT ALLOWED.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
473	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FOURTH DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
474	THE DME ITEM BILLED HAS BEEN PREVIOUSLY PAID. THIS BILLING EXCEEDS THE MAXIMUM NUMBER OF BILLINGS ALLOWED BY MEDICAID.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
475	AN OUTPATIENT CLAIM CANNOT BE BILLED WITHIN 72 HOURS OF AN INPATIENT STAY. ALL CHARGES MUST BE INCLUDED ON INPATIENT CLAIM.		...	60	CHARGES FOR OUTPATIENT SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN A PERIOD OF TIME PRIOR TO OR AFTER INPATIENT SERVICES
476	MULTIPLE DENTAL PROPHYS HAVE BEEN BILLED. PROPHYS AND/OR PROPHYS WITH FLUORIDE ARE PAYABLE EVERY 6 MONTHS (3 MONTHS IF MEDICAL NEED IS SHOWN)	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
477	THE LIMIT ON X-RAYS LISTED IN THE MEDICAID PROVIDER MANUAL HAS BEEN EXCEEDED.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
480	THIS CLAIM HAS BEEN DENIED BUT IS BEING SUBMITTED FOR MEDICALLY NEEDY SPENDDOWN CONSIDERATION.		...	178	PATIENT HAS NOT MET THE REQUIRED SPEND DOWN REQUIREMENTS
482	CASE MANAGEMENT SERVICES FOR CHRONICALLY MENTALLY ILL (CMI) ARE PAYABLE BY MERIT.		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
483	THESE SERVICES HAVE BEEN IDENTIFIED AS BEING MENTAL HEALTH BASED ON THE DIAGNOSIS. THESE MUST BE SUBMITTED TO THE MENTAL HEALTH CONTRACTOR.		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
484	THE RECIPIENT IS ENROLLED IN THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE). SERVICE NOT COVERED UNDER FEE-FOR-SERVICE MEDICAID.		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN

485	LANGUAGE SERVICE CODE MUST BE BILLED WITH A PAYABLE MEDICAID SERVICE.	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	B15	THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE ...
490	THE SEVENTH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
499	INVALID OR MISSING PATIENT MANAGER REFERRAL FOR RECIPIENT	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
500	THERE IS NO RECORD OF AN APPROVED CASE PLAN FOR THIS SERVICE ON THIS DATE. CONTACT DHS FOR UPDATES OF SERVICES APPROVED ON CASE PLAN.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	197	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT ABSENT
501	THE PRIOR AUTHORIZATION SUBMITTED FOR THIS SERVICE WAS NOT APPROVED.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	39	SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED
503	THE HCPCS PROCEDURE CODE IS NOT A VALID CODE FOR OUTPATIENT CLAIMS.		...	5	THE PROCEDURE CODE/TYPE OF BILL IS INCONSISTENT WITH THE PLACE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
504	REVENUE CODE 187 CANNOT BE BILLED FOR DATES OF SERVICE PRIOR TO JULY 1, 2000.	M50	MISSING/INCOMPLETE/INVALID REVENUE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

505	THE SURGERY BILLED IS A NON-PAYABLE COSMETIC SURGERY.	N383	NOT COVERED WHEN DEEMED COSMETIC.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
506	INVALID DATA IS CONTAINED IN THE CARRIER DENIED COVERAGE FIELD.	N48	CLAIM INFORMATION DOES NOT AGREE WITH INFORMATION RECEIVED FROM OTHER INSURANCE CARRIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
507	THE SURGICAL PROCEDURE CODE (10000-69999) REQUIRES A REVENUE CODE OF 36X, 45X, 49X OR 76X.		...	199	REVENUE CODE AND PROCEDURE CODE DO NOT MATCH
508	THE REVENUE CODES 36X OR 49X REQUIRE A HCPCS PROCEDURE CODE.	M20	MISSING/INCOMPLETE/INVALID HCPCS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
510	THE BILLING PROVIDER IS NOT THE PROVIDER THAT WAS AUTHORIZED TO PERFORM THE SERVICE ON THE PRIOR AUTHORIZATION.	N54	CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
511	THE SERVICE BILLED SHOWS A PROCEDURE CODE OR PROVIDER NUMBER THAT WAS NOT SHOWN ON THE CARE PLAN. THE CARE PLAN AND THE CLAIM MUST MATCH.	N54	CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

512	A LINE ITEM ON THE INPATIENT CLAIM HAS BEEN DENIED, THEREFORE, THE ENTIRE CLAIM MUST BE DENIED.	M50	MISSING/INCOMPLETE/INVALID REVENUE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
513	MULTIPLE EXTRACTIONS MUST BE BILLED WITH D7110 FOR THE FIRST AND D7120 FOR EACH ADDITIONAL TOOTH.	N56	PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
514	MEDICAID RECORDS DO NOT SHOW THE PROVIDER APPROVED TO BILL THE SERVICE SUBMITTED.	N65	PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF SERVICE/PROVIDER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
515	THERE IS A TRANSPLANT REVENUE CODE OF 362 AND A TRANSPLANT ICD-9-CM SURGICAL PROCEDURE CODE IS NOT ON THE CLAIM.		...	199	REVENUE CODE AND PROCEDURE CODE DO NOT MATCH
516	POSSIBLE INTERIM CLAIM. INTERIM BILLINGS ARE NOT ACCEPTED ON THE TYPE OF CLAIM SUBMITTED.		...	135	INTERIM BILLS CANNOT BE PROCESSED
517	THE DATES OF SERVICE ON THE CLAIM DO NOT MATCH THE DATES ON THE PRIOR AUTHORIZATION.	N54	CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
518	USE VACCINE SUPPLY PROVIDED BY DEPARTMENT OF PUBLIC HEALTH		...	B8	ALTERNATIVE SERVICES WERE AVAILABLE, AND SHOULD HAVE BEEN UTILIZED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

520	THE CLAIM INDICATES AN ACCIDENT; THE DIAGNOSIS DOES NOT INDICATE AN ACCIDENT.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
521	THE EIGHTH DIAGNOSIS IS NOT ON THE DIAGNOSIS FILE.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
525	A PANORAMIC OR A FULL-MOUTH X-RAY IS PAYABLE ONCE EVERY 5 YEARS UNLESS DOCUMENTATION OF NECESSITY IS PROVIDED ON THE CLAIM.		...	272	COVERAGE/PROGRAM GUIDELINES WERE NOT MET
530	THE ADMISSION HOUR IS EITHER MISSING OR INVALID. VALID VALUES ARE 00-23 AND 99.	N46	MISSING/INCOMPLETE/INVALID ADMISSION HOUR.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
532	THE 9TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
533	A RELEVANT DIAGNOSIS IS REQUIRED TO ESTABLISH THE MEDICAL NECESSITY FOR THIS SERVICE.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	50	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
535	SKILLED NURSING CARE WITH A MENTAL HEALTH DIAGNOSIS MUST BE BILLED TO IOWA PLAN.		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
541	A MAXIMUM OF 12 MENTAL HEALTH VISITS CAN BE BILLED PER YEAR. AFTER 12 VISITS, CLAIMS MUST BE SUBMITTED TO IOWA PLAN.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED

544	MENTAL HEALTH SERVICES MUST BE BILLED TO MBC OF IOWA		...	24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
547	THE SERVICE BILLED REPRESENTS FRAGMENTED AUDIOMETRY CHARGES.	N20	SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
552	THE THIRD SURGICAL PROCEDURE CODE IS NOT ON THE PROCEDURE FILE.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
557	DUPLICATE J-CODE		...	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
558	OBSERVATION ROOM NOT PAYABLE FOR MENTAL HEALTH DIAGNOSIS. CLAIM MUST BE BILLED TO MENTAL HEALTH CONTRACTOR.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	109	CLAIM/SERVICE NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 | LAST MODIFIED: 01/29/2012...
559	THE FOURTH SURGICAL PROCEDURE CODE IS NOT ON FILE.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
560	THE FIFTH SURGICAL PROCEDURE CODE IS NOT ON FILE.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

561	THE SURGICAL PROCEDURE CODE IS NOT ON FILE.	M67	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
562	THE FOURTH SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS AGE.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
563	THE FIFTH SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS AGE.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
564	THE SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS AGE.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
565	THE FOURTH SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS SEX.		...	7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
566	THE FIFTH SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS SEX.		...	7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
567	THE SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS SEX.		...	7	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

568	THE FIRST SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N216	WE DO NOT OFFER COVERAGE FOR THIS TYPE OF SERVICE OR THE PATIENT IS NOT ENROLLED IN THIS PORTION OF OUR BENEFIT PACKAGE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
569	THE SECOND SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N216	WE DO NOT OFFER COVERAGE FOR THIS TYPE OF SERVICE OR THE PATIENT IS NOT ENROLLED IN THIS PORTION OF OUR BENEFIT PACKAGE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
570	THE THIRD SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N216	WE DO NOT OFFER COVERAGE FOR THIS TYPE OF SERVICE OR THE PATIENT IS NOT ENROLLED IN THIS PORTION OF OUR BENEFIT PACKAGE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
571	THE FOURTH SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N216	WE DO NOT OFFER COVERAGE FOR THIS TYPE OF SERVICE OR THE PATIENT IS NOT ENROLLED IN THIS PORTION OF OUR BENEFIT PACKAGE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
572	THE FIFTH SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N216	WE DO NOT OFFER COVERAGE FOR THIS TYPE OF SERVICE OR THE PATIENT IS NOT ENROLLED IN THIS PORTION OF OUR BENEFIT PACKAGE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
573	THE SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID.	N216	WE DO NOT OFFER COVERAGE FOR THIS TYPE OF SERVICE OR THE PATIENT IS NOT ENROLLED IN THIS PORTION OF OUR BENEFIT PACKAGE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

574	THE FIRST SURGICAL PROCEDURE CODE REQUIRED MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
575	THE SECOND SURGICAL PROCEDURE CODE REQUIRED MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
576	THE THIRD SURGICAL PROCEDURE CODE REQUIRED MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
577	THE FOURTH SURGICAL PROCEDURE CODE REQUIRED MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
578	THE FIFTH SURGICAL PROCEDURE CODE REQUIRED MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
579	THE SURGICAL PROCEDURE CODE REQUIRED MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

580	THE FIRST SURGICAL PROCEDURE CODE REQUIRES MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
581	THE SECOND SURGICAL PROCEDURE CODE REQUIRES MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
582	THE THIRD SURGICAL PROCEDURE CODE REQUIRES MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
583	THE FOURTH SURGICAL PROCEDURE CODE REQUIRES MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
584	THE FIFTH SURGICAL PROCEDURE CODE REQUIRES MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
585	THE SURGICAL PROCEDURE REQUIRES MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

586	HOSPICE CLAIMS FOR REVENUE CODE 651 AND/OR 652 REQUIRE VALUE CODE 61 AND THE MSA CODE NUMBER(VALUE AMOUNT).	M49	MISSING/INCOMPLETE/INVALID VALUE CODE(S) OR AMOUNT(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
587	INVALID DIAGNOSIS AND/OR PROCEDURE CODE FOR FAMILY PLANNING OR MEMBER HAS BEEN IDENTIFIED WITH RELEVANT ADDRESS ISSUE.	N246	STATE REGULATED PATIENT PAYMENT LIMITATIONS APPLY TO THIS SERVICE.	A1	CLAIM/SERVICE DENIED. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.
588	INVALID SURGICAL PROCEDURE CODE FOR FAMILY PLANNING.	N246	STATE REGULATED PATIENT PAYMENT LIMITATIONS APPLY TO THIS SERVICE.	A1	CLAIM/SERVICE DENIED. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.
589	THE SYSTEM COULD NOT DETERMINE THE PROVIDER ID. IME DEFAULT USED		...	208	NATIONAL PROVIDER IDENTIFIER - NOT MATCHED
590	BILLING NPI ON CLAIM CONFLICTS WITH NPI ON FILE		...	208	NATIONAL PROVIDER IDENTIFIER - NOT MATCHED
591	PAY TO NPI ON CLAIM CONFLICTS WITH NPI ON FILE		...	208	NATIONAL PROVIDER IDENTIFIER - NOT MATCHED
592	RENDERING NPI ON CLAIM CONFLICTS WITH NPI ON FILE		...	208	NATIONAL PROVIDER IDENTIFIER - NOT MATCHED
600	RENDERING AND PAY TO PROVIDER/NPI DON'T HAVE THE SAME TAX ID NUMBER		...	208	NATIONAL PROVIDER IDENTIFIER - NOT MATCHED
604	SERVICES BILLED ON CLAIM DO NOT MATCH SERVICES APPROVED ON PRIOR AUTHORIZATION.	N54	CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
609	CLAIM SUBMITTED DOES NOT MATCH LEVEL OF CARE APPROVAL FROM IFMC. IF CARE IS NON-ACUTE, CORRECT COND CODE & BILL TYPE MUST BE USED.	N188	THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

613	UNITS BILLED ON CLAIM EXCEED THE UNITS APPROVED ON THE PRIOR AUTHORIZA- TION. CLAIM OR PRIOR AUTHORIZATION MUST BE CORRECTED.	N54	CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
618	ANESTHESIA TIME UNITS MUST BE SUBMITTED - 1 UNIT PER MINUTE - IN THE UNITS FIELD ON THE CLAIM FORM.	N203	MISSING/INCOMPLETE/INVALID ANESTHESIA TIME/UNITS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
621	MISSING OR INVALID DIAGNOSIS INDICATOR. VALID DIAGNOSIS INDICATORS ARE 1 - 4.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
624	THE DATE THE HOME HEALTH PLAN WAS ESTABLISHED IS MISSING OR INVALID.	M135	MISSING/INCOMPLETE/INVALID PLAN OF TREATMENT.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
626	NON-COVERED CHARGES GREATER THAN SUBMITTED CHARGE	M79	MISSING/INCOMPLETE/INVALID CHARGE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
631	A VALID TOOTH SURFACE CODE IS MISSING.	N75	MISSING/INCOMPLETE/INVALID TOOTH SURFACE INFORMATION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

632	THE TOOTH NUMBER IS INVALID OR NOT VALID FOR THE PROCEDURE CODE.	N37	MISSING/INCOMPLETE/INVALID TOOTH NUMBER/LETTER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
633	INVALID TOOTH SURFACE OR QUADRANT.	N75	MISSING/INCOMPLETE/INVALID TOOTH SURFACE INFORMATION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
634	THE REQUIRED TOOTH NUMBER IS EITHER MISSING OR INVALID.	N37	MISSING/INCOMPLETE/INVALID TOOTH NUMBER/LETTER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
635	PROCEDURE NOT PAYABLE WITH TOOTH NUMBER OR LETTER	N37	MISSING/INCOMPLETE/INVALID TOOTH NUMBER/LETTER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
636	CRITERIA FOR ANNUAL ROUTINE PHYSICAL EXAMINATION NOT MET. PLEASE REFER TO INFORMATIONAL RELEASE NO. 640.		...	272	COVERAGE/PROGRAM GUIDELINES WERE NOT MET
642	THE 10TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

643	THE 10TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
644	THE 10TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
645	THE 10TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
646	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 10TH DIAGNOSIS CODE		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
647	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 10TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
653	THE IOWACARE PROGRAM ENDED 12/31/13 AND CLAIMS ARE NO LONGER ACCEPTED. PLEASE CONTACT IME PROVIDER SERVICES WITH ANY QUESTIONS.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	29	THE TIME LIMIT FOR FILING HAS EXPIRED
655	PROVIDER TYPE MUST BE A PHYSICAN, AMBULANCE, OR NURSE PRACTITIONER.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	242	SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS
657	SERVICE NOT COVERED BY IOWA CARE. (OR) CLAIM IS NOT REFERRED BY BROADLAWNS PHYSICIANS OR HOSPITAL.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	204	THIS SERVICE/EQUIPMENT/DRUG IS NOT COVERED UNDER THE PATIENT'S CURRENT BENEFIT PLA
658	SERVICE NOT COVERED BY IOWACARE - 300% OB GROUP POLICY	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	204	THIS SERVICE/EQUIPMENT/DRUG IS NOT COVERED UNDER THE PATIENT'S CURRENT BENEFIT PLA
659	THE BILLED SERVICE IS NOT COVERED FOR THE MEMBER.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	256	SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT

661	THE CLAIM SUBMITTED REPRESENTS AN INTERIM BILL. HOWEVER, UNDER THE DRG REIMBURSEMENT SYSTEM ONLY DISCHARGE BILLS CAN BE SUBMITTED.		...	135	INTERIM BILLS CANNOT BE PROCESSED
665	FRAGMENTED CHARGES WERE BILLED FOR TOOTH EXTRACTION. ONLY 1 CHARGE CAN BE BILLED FOR EACH TOOTH EXTRACTION, INCLUDING REMOVAL & SUTURING.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
666	A 3-MONTH SUPPLY IS THE MAXIMUM TIME PERIOD THAT CAN BE BILLED. THE QUANTITY BILLED EXCEEDS THE NUMBER ALLOWED FOR A 3-MONTH PERIOD.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
670	THE COVERED DAYS BILLED WERE REDUCED TO THE NUMBER OF DAYS OF MEDICAID ELIGIBILITY.		...	238	CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE, THIS IS THE REDUCTION FOR THE INELIGIBLE PERIOD. (USE ONLY WITH GROUP CODE PR
671	THE RECIPIENT WAS NOT ELIGIBLE FOR MEDICAID FOR THE ENTIRE DATE SPAN BILLED.		...	238	CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE, THIS IS THE REDUCTION FOR THE INELIGIBLE PERIOD. (USE ONLY WITH GROUP CODE PR
672	THE 11TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
673	THE 11TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
674	THE 11TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

675	THE 11TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
676	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 11TH DIAGNOSIS CODE		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
677	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 11TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
680	THE RECIPIENT'S AGE ON THE ADMISSION DATE IS NOT WITHIN THE MINIMUM & MAXIMUM SPECIFIED FOR THE FIFTH DIAGNOSIS CODE BILLED.		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
682	THE 12TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
683	THE 12TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
684	THE 12TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

685	THE 12TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
686	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 12TH DIAGNOSIS CODE		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
687	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 12TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
688	THE 13TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
689	THE 13TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
690	THE 13TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
691	THE 13TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

692	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 13TH DIAGNOSIS CODE		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
693	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 13TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
696	ATTENDING PROVIDER NOT ENROLLED WITH IOWA MEDICAID AS REQUIRED BY THE AFFORDABLE CARE ACT	N630	REFERRAL NOT AUTHORIZED BY ATTENDING PHYSICIAN.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
697	NUMBER OF TOTAL UNITS BILLED FOR ADMINISTRATION CODE (90460) SHOULD NOT BE MORE THAN VACCINES BILLED.	N430	PROCEDURE CODE IS INCONSISTENT WITH THE UNITS BILLED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
698	THE DISCHARGE HOUR IS MISSING OR INVALID. VALID VALUES ARE 00-23, AND 99.	N50	MISSING/INCOMPLETE/INVALID DISCHARGE INFORMATION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
699	INPATIENT AND OUTPATIENT CLAIM WITHIN 72 HRS OF EACH OTHER CANNOT BE BILLED SEPARATELY.		...	60	CHARGES FOR OUTPATIENT SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN A PERIOD OF TIME PRIOR TO OR AFTER INPATIENT SERVICES
700	POS EDIT - MISSING UNIT DOSE INDICATOR		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

701	MISSING OR INVALID BIN.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
702	MISSING OR INVALID VERSION NUMBER. CONTACT YOUR SOFTWARE VENDOR.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
703	MISSING OR INVALID TRANSACTION CODE. CONTACT YOUR SOFTWARE VENDOR.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
704	MISSING OR INVALID PROCESSOR CONTROL NUMBER. CONTACT YOUR SOFTWARE VENDOR.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
706	MISSING OR INVALID GROUP NUMBER. RECIPIENT PLAN MUST HAVE 1906530.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
707	POS EDIT - MISSING OTHER PAYER AMOUNT PAID		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

708	MISSING OR INVALID PERSON CODE. CONTACT YOUR SOFTWARE VENDOR.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
709	MISSING OR INVALID BIRTHDATE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
710	MISSING OR INVALID SEX CODE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
711	MISSING OR INVALID RELATIONSHIP CODE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
712	MISSING OR INVALID CUSTOMER LOCATION CODE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
713	MISSING OR INVALID OTHER COVERAGE CODE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

714	MISSING OR INVALID ELIGIBILITY OVERRIDE CODE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
715	POS EDIT - MISSING COMPOUND INGREDIENT QUANTITY		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
716	POS EDIT - MISSING PRIOR AUTHORIZATION TYPE CODE		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
717	MISSING OR INVALID NEW/REFILL INDICATOR.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
718	POS EDIT - MISSING DISPENSING STATUS		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
719	MISSING DAYS SUPPLY OR MAXIMUM DAYS SUPPLY EXCEEDED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

720	MISSING OR INVALID COMPOUND CODE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
721	POS EDIT - MISSING COMPOUND PRODUCT ID		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
723	MISSING OR INVALID INGREDIENT COST.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
724	MISSING OR INVALID SALES TAX.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
725	INVALID DEA NUMBER.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
726	B3 SERVICE BILLED FOR NON MEDICALLY FRAIL MEMBER.	96	NON-COVERED CHARGE(S).	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.

728	MISSING OR INVALID DATE PRESCRIPTION WRITTEN.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
729	MISSING OR INVALID NUMBER OF REFILLS AUTHORIZED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
730	MISSING OR INVALID PRIOR AUTHORIZATION NUMBER.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
732	THE CLAIM REQUIRES DOCUMENTATION OF MEDICAL NECESSITY WHICH WAS NOT PROVIDED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
733	MISSING OR INVALID PRESCRIPTION ORIGIN CODE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
734	MISSING OR INVALID PRESCRIPTION DENIAL OVERRIDE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

735	MISSING OR INVALID PRIMARY PRESCRIBER.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
736	MISSING OR INVALID CLINIC ID.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
738	MISSING OR INVALID BASIS OF COST.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
739	MISSING OR INVALID DIAGNOSIS CODE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
741	THIRD PARTY INSURANCE ON RECIPIENT FILE AND NOT ON CLAIM. CLAIM SET TO PAY.	N479	MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
750	CORRECT CODING EDIT - LAB PANELS	M15	SEPARATELY BILLED SERVICES/TESTS HAVE BEEN BUNDLED AS THEY ARE CONSIDERED COMPONENTS OF THE SAME PROCEDURE. SEPARATE PAYMENT IS NOT ALLOWED.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...

751	NON-MATCHED GROUP NUMBER OR DATE OF SERVICE IS TOO OLD.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
753	NON-MATCHED PERSON CODE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
755	NON-MATCHED NDC PACKAGE SIZE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
757	NON-MATCHED PA/MC NUMBER.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
758	NON-MATCHED PRIMARY PRESCRIBER.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
759	NON-MATCHED CLINIC ID		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

760	DRUG NOT COVERED FOR RECIPIENT AGE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
761	DRUG NOT COVERED FOR RECIPIENT GENDER.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
762	PATIENT/CARD HOLDER ID NAME MISMATCH.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
763	NDC NOT COVERED FOR THIS PATIENT.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
764	CLAIM SUBMITTED DOES NOT MATCH PRIOR AUTHORIZATION.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
766	RECIPIENT AGE EXCEEDS MAXIMUM AGE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

767	THE RECIPIENT IS NOT ELIGIBLE FOR THE DATE OF SERVICE BILLED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
768	FILLED AFTER COVERAGE EXPIRED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
769	FILLED AFTER COVERAGE TERMINATED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
771	PRESCRIBER IS NOT COVERED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
772	PRIMARY PRESCRIBER IS NOT COVERED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
773	REFILLS ARE NOT COVERED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

775	PRIOR AUTHORIZATION IS REQUIRED FOR THE DRUG BILLED.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
778	CLAIM DOES NOT MEET GUIDELINES FOR BILLING COMPOUNDS - PAPER CLAIM, NDC OF EACH INGREDIENT, ONE LEGEND PRODUCT, ETC.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
779	THE PRESCRIPTION WAS REFILLED TOO SOON BASED ON THE DAYS SUPPLY AND THE QUANTITY SUBMITTED (COMBINING THIS AND PAST CLAIMS).		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
780	DRUG-DIAGNOSIS MISMATCH.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
782	DATED FILLED IS AFTER DATE CLAIM WAS RECEIVED. DATE OF SERVICE SHOULD BE REVIEWED FOR ACCURACY.		...	110	BILLING DATE PREDATES SERVICE DATE
783	INPATIENT READMISSION WITHIN 7 DAYS FOR SAME CONDITION PRIOR TO 7/1/15 OR WITHIN 30 DAYS FOR THE SAME CONDITION AFTER 7/1/15.		...	249	THIS CLAIM HAS BEEN IDENTIFIED AS A READMISSION. (USE ONLY WITH GROUP CODE CO
784	REVERSAL NOT PROCESSED. COULD NOT FIND ORIGINAL CLAIM BASED ON THE CRITERIA SUBMITTED.	N152	MISSING/INCOMPLETE/INVALID REPLACEMENT CLAIM INFORMATION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

786	SUBMIT MANUAL RESERVE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
788	DUR REJECT FOR HIGH DOSAGE OR THERAPEUTIC DUPLICATION.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
790	HOST SYSTEM UNAVAILABLE.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
799	THIS CLAIM CANNOT BE PROCESSED ONLINE THROUGH THE POINT OF SALE (POS) SYSTEM - SUFFICIENT DOCUMENTATION WAS NOT PROVIDED FOR ADJUDICATION.		...	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
800	PROVIDER IS NOT AN ELIGIBLE PROVIDER FOR THE DATE OF SERVICE BILLED ON THE CLAIM FORM.	N570	MISSING/INCOMPLETE/INVALID CREDENTIALING DATA.	B7	THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
801	THE NATIONAL DRUG CODE BILLED IS NO LONGER VALID. THE NDC HAS BEEN DISCONTINUED FOR OVER ONE YEAR.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

802	THE SUBMITTED DAYS SUPPLY IS MISSING, INVALID, OR GREATER THAN THE MAXIMUM QUANTITY ALLOWED(MAXIMUM DAYS SUPPLY).	N378	MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
804	INVALID PRESCRIBING PROVIDER NUMBER. IF RECIPIENT IS LOCKED-IN, THE WRONG LOCK-IN DOCTOR WAS SHOWN.	N31	MISSING/INCOMPLETE/INVALID PRESCRIBING PROVIDER IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
805	A MODIFIER IS REQUIRED WHEN BILLING THE PROFESSIONAL COMPONENT ONLY AND THE PLACE OF SERVICE IS HOSPITAL INPATIENT OR OUTPATIENT.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
806	THE 14TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
807	THE 14TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
808	THE 14TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

809	THE 14TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
810	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 14TH DIAGNOSIS CODE		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
811	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 14TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
814	CROSS-OVER CLAIM CANNOT BE USED TO MEET SPENDDOWN. SUBMIT A MEDICAID CLAIM WITH THE MEDICARE PAYMENT AS THIRD-PARTY PAYMENT.		...	178	PATIENT HAS NOT MET THE REQUIRED SPEND DOWN REQUIREMENTS
816	APC GROUPER ERROR-COMPOSITE E/M CONDITION NOT MET FOR OBSERVATION AND LINE ITEM DATE FOR CODE G0378 IS 1/1	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
817	APC GROUPER ERROR - OVERALL CLAIM DISPOSITION CAUSED DENIAL	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
818	APC GROUPER ERROR - NON ALLOWED SERVICE FOR APC	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

819	APC GROUPER ERROR - INVALID CODE APC	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
820	APC GROUPER ERROR - PARTIAL HOSPITALIZATION	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
821	APC GROUPER ERROR - NOT PROCESSED BY GROUPER	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
822	APC GROUPER ERROR - NON IMPLANTABLE DME	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
823	ERROR FROM APC GROUPER	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
824	APC GROUPER ERROR 21 - MEDICAL VISIT ON THE SAME DAY AS A TYPE T OR S PROCEDURE WITHOUT MODIFIER 25	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

825	APC GROUPER ERROR 039 - MUTUALLY EXCLUSIVE PROCEDURE THAT WOULD BE ALLOWED BY NCCI IF APPROPRIATE MODIFIER WERE PRESENT	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
826	APC GROUPER ERROR 040 - CODE2 OF A CODE PAIR THAT WOULD BE ALLOWED BY NCCI IF APPROPRIATE MODIFIER WERE PRESENT	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
827	APC GROUPER ERROR 064 - AT SERVICE NOT PAYABLE OUTSIDE THE PARTIAL HOSPITALIZATION PROGRAM	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
828	AN HOURLY HOME HEALTH REVENUE CODE WAS BILLED. HOURLY HOME HEALTH REVENUE CODES ARE ONLY PAYABLE FOR EPSDT OR APPROVED ETP SERVICES.		...	6	THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
832	THE MAXIMUM DOLLAR AMOUNT ALLOWED PER YEAR HAS BEEN EXCEEDED.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
833	THIS DENTAL SERVICE IS NOT COVERED FOR AN ADULT EFFECTIVE MARCH 1, 2002.	N129	NOT ELIGIBLE DUE TO THE PATIENT'S AGE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

841	APC GROUPER ERROR - NO GROUPER DESCRIPTION - OFTEN HAPPENS WHEN THERE ARE NO PAYABLE LINES	M16	ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
842	APC GROUPER ERROR 001 - INVALID DIAGNOSIS CODE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
843	APC GROUPER ERROR 005 - E-DIAGNOSIS CODE CAN NOT BE USED AS PRINCIPAL DIAGNOSIS	MA63	MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
844	APC GROUPER ERROR 006 - INVALID PROCEDURE CODE	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
845	APC GROUPER ERROR 017 - INAPPROPRIATE SPECIFICATION OF BILATERAL PROCEDURE	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
846	APC GROUPER ERROR 042 - MULTIPLE MEDICAL VISITS ON SAME DAY WITH SAME REVENUE CODE WITHOUT CONDITION CODE G0	M44	MISSING/INCOMPLETE/INVALID CONDITION CODE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

847	APC GROUPER ERROR 048 - REVENUE CENTER REQUIRES HCPCS	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
848	CORRECT CODING EDIT - ADD ON	N122	ADD-ON CODE CANNOT BE BILLED BY ITSELF.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
849	CORRECT CODING EDIT - AGE/GENDER	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
850	CORRECT CODING EDIT - CCI RULE		...	236	THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH...
851	CORRECT CODING EDIT - E/M		...	236	THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH...

852	CORRECT CODING EDIT - GLOBAL SURGERY	N525	THESE SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN THE GLOBAL PERIOD OF ANOTHER SERVICE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
853	CORRECT CODING EDIT - INCIDENTALS	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
854	CORRECT CODING EDIT - MEDICAL NECESSITY	N115	THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,...	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
855	CORRECT CODING EDIT - MULTIPLE SURGEONS		...	236	THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH...
856	CORRECT CODING EDIT - MULTIPLE UNITS	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

857	CORRECT CODING EDIT - NEW VISIT		...	236	THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH...
858	CORRECT CODING EDIT - OB	N525	THESE SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN THE GLOBAL PERIOD OF ANOTHER SERVICE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
859	CORRECT CODING EDIT - UNLISTED	N350	MISSING/INCOMPLETE/INVALID DESCRIPTION OF SERVICE FOR A NOT OTHERWISE CLASSIFIED (NOC) CODE OR FOR AN UNLISTED/BY REPORT PROCEDURE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
860	CORRECT CODING EDIT - DUPLICATE	N522	DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM.	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
861	THE 15TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	146	DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED
862	THE 15TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
863	THE 15TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

864	THE 15TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
865	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 15TH DIAGNOSIS CODE		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
866	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 15TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
867	THE 16TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	146	DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED
868	THE 16TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
869	THE 16TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
870	THE 16TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
871	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 16TH DIAGNOSIS CODE		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

872	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 16TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
873	THE 17TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	146	DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED
874	THE 17TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
875	THE 17TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
876	THE 17TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
877	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 17TH DIAGNOSIS CODE		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
878	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 17TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
879	THE DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	146	DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED
880	THE DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID/OR MEDICAL NECESSITY NOT ESTABLISHED WITH THE DIAGNOSIS BILLED.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

881	THE DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
882	THE DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
883	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE DIAGNOSIS CODE		...	9	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
884	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
885	CORRECT CODING EDIT - MUE	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	50	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
886	MEMBER IS NOT ELIGIBLE/ATTESTED FOR DATE OF SERVICE.		...	177	PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY REQUIREMENTS
887	MCO PAYMENT REDUCTION APPLIED.		...	59	PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES. (FOR EXAMPLE MULTIPLE SURGERY OR DIAGNOSTIC IMAGING, CONCURRENT ANESTHESIA.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PR...
888	CLAIM WAS SUBMITTED ELECTRONICALLY AND REQUIRES MEDICAL REVIEW. PLEASE RESUBMIT ON THE CORRECT FORM AND INCLUDE APPROPRIATE DOCUMENTATION.	N587	POLICY BENEFITS HAVE BEEN EXHAUSTED.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED

889	INVALID WAIVER FOR RESPITE	N597	ADJUSTED BASED ON A MEDICAL/DENTAL PROVIDER'S APPORTIONMENT OF CARE BETWEEN RELATED INJURIES AND OTHER UNRELATED MEDICAL/DENTAL CONDITIONS/INJURIES.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
890	(Null)		...	133	THE DISPOSITION OF THIS SERVICE LINE IS PENDING FURTHER REVIEW. (USE ONLY WITH GROUP CODE OA). USAGE: USE OF THIS CODE REQUIRES A REVERSAL AND CORRECTION WHEN THE SERVICE LINE IS FINALIZED (USE ONLY IN LOOP 2110 CAS SEGMENT OF THE 835 OR LOOP 2430 OF ...
891	THE RECIPIENT HAS LIMITED ELIGIBILITY THROUGH PRESUMPTIVE ELIGIBILITY COVERAGE. THE SERVICE IS NOT AMBULATORY SERVICE AND IS NOT COVERED.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
892	NO APG ASSIGNED BY APG GROUPER BASED ON DIAGNOSIS/PROCEDURE(S) SUBMITTED. MAY BE PACKAGED WITH OTHER SERVICES BILLED ON CLAIM.	M15	SEPARATELY BILLED SERVICES/TESTS HAVE BEEN BUNDLED AS THEY ARE CONSIDERED COMPONENTS OF THE SAME PROCEDURE. SEPARATE PAYMENT IS NOT ALLOWED.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
893	DRG GROUPER WAS NOT ABLE TO ASSIGN A DRG BASED ON THE DIAGNOSIS AND/ OR PROCEDURE CODING SUBMITTED.		...	A8	UNGROUPABLE DRG
894	OPERATING ROOM PROCEDURE WAS NOT PROCESSED BY DRG GROUPER. VERIFY CODING SUBMITTED.		...	A8	UNGROUPABLE DRG
895	DATE OF ONSET FOR ACUTE CARE CANNOT BE MORE THAN SIX MONTHS BEFORE SERVICE DATE.	MA100	MISSING/INCOMPLETE/INVALID DATE OF CURRENT ILLNESS OR SYMPTOMS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

897	THE DATE OF ONSET BILLED IS MISSING OR INVALID.	MA100	MISSING/INCOMPLETE/INVALID DATE OF CURRENT ILLNESS OR SYMPTOMS.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
898	LAST X-RAY DATE MORE THAN 365 DAYS BEFORE FIRST DATE OF SERVICE.	M1	X-RAY NOT TAKEN WITHIN THE PAST 12 MONTHS OR NEAR ENOUGH TO THE START OF TREATMENT.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
899	A DRG BASE RATE IS NOT AVAILABLE FOR THE SERVICE BILLED.	N208	MISSING/INCOMPLETE/INVALID DRG CODE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
900	CLAIM IS IN PROCESS. PLEASE DO NOT RESUBMIT THE CLAIM PRIOR TO PAYMENT OR DENIAL.	N185	ALERT: DO NOT RESUBMIT THIS CLAIM/SERVICE.	133	THE DISPOSITION OF THIS SERVICE LINE IS PENDING FURTHER REVIEW. (USE ONLY WITH GROUP CODE OA). USAGE: USE OF THIS CODE REQUIRES A REVERSAL AND CORRECTION WHEN THE SERVICE LINE IS FINALIZED (USE ONLY IN LOOP 2110 CAS SEGMENT OF THE 835 OR LOOP 2430 OF ...
901	THE MEMBER WAS NOT,AT LEAST,AGE 21 WHEN COUNSELING WAS PROVIDED.	N129	NOT ELIGIBLE DUE TO THE PATIENT'S AGE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
902	THE STERILIZATION CONSENT FORM IS NOT LEGIBLE OR IS COMPLETED INCORRECTLY.	N228	INCOMPLETE/INVALID CONSENT FORM.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...

903	PRIOR AUTHORIZATION NUMBER IS INCORRECT.	M62	MISSING/INCOMPLETE/INVALID TREATMENT AUTHORIZATION CODE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
904	A 30-DAY WAITING PERIOD FOR STERILIZATION WAS NOT MET, 180 DAY MAXIMUM EXCEEDED OR 72 HR WAITING PERIOD FOR EMERGENCY STERILIZATION WAS NOT MET		...	272	COVERAGE/PROGRAM GUIDELINES WERE NOT MET
905	THE PERCENTAGE OF THE PROCEDURE THAT WAS COMPLETED MUST BE INCLUDED IN THE OPERATIVE REPORT.	N233	INCOMPLETE/INVALID OPERATIVE NOTE/REPORT.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
906	THE PHYSICIAN, MEMBER, COUNSELOR AND/OR INTERPRETER SIGNATURE/DATE ARE MISSING OR INVALID ON THE CONSENT FORM.	N228	INCOMPLETE/INVALID CONSENT FORM.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
907	ADD-ON CODES MUST ALWAYS BE BILLED IN CONJUNCTION WITH THE APPROPRIATE PRIMARY CODE.	N122	ADD-ON CODE CANNOT BE BILLED BY ITSELF.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
908	THE PROCEDURE/SURGERY WAS PERFORMED OUTSIDE OF AN OR FOR TREATMENT OF COMPLICATIONS OF ANOTHER SURGERY AND IS NOT SEPARATELY REIMBURSABLE.	N390	THIS SERVICE/REPORT CANNOT BE BILLED SEPARATELY.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...

909	OFFICE VISIT NOTES/MEDICAL RECORD/THERAPY NOTES ARE REQUIRED TO REVIEW THIS SERVICE. PLEASE RESUBMIT CLAIM WITH DOCUMENTATION.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
910	REQUIRED FIELDS ARE BLANK ON THE STERILIZATION CONSENT FORM.	N228	INCOMPLETE/INVALID CONSENT FORM.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
911	A VALID TOOTH NUMBER OR SURFACE IS REQUIRED FOR THIS PROCEDURE.	N75	MISSING/INCOMPLETE/INVALID TOOTH SURFACE INFORMATION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
912	THE ABORTION CERTIFICATE WAS NOT ATTACHED/MUST BE THE REVISED 07/11 VERSION.	N398	MISSING ELECTIVE CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
913	A PHYSICIAN SIGNED PROCEDURE/SURGICAL REPORT IS REQUIRED.	M29	MISSING OPERATIVE NOTE/REPORT.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
914	THE MEDICAL NECESSITY WAS NOT SHOWN FOR THE SERVICE AND/OR UNITS BILLED.	N163	MEDICAL RECORD DOES NOT SUPPORT CODE BILLED PER THE CODE DEFINITION.	50	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

915	AN NCCI EDIT EXISTS FOR THE CODE COMBINATION BILLED.		...	236	THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH...
916	THE DIAGNOSIS DOES NOT SUPPORT THE SERVICE BILLED.		...	11	THE DIAGNOSIS IS INCONSISTENT WITH THE PROCEDURE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
917	A DIAGNOSIS OR DOCUMENTATION INDICATING THE OUTCOME OF THE DELIVERY IS REQUIRED TO REVIEW THE CLAIM.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
918	UNLISTED PROCEDURES CPT/HCPS CODES MUST BE CLEARLY IDENTIFIED IN BOX 19 ON CLAIM FORM.	N350	MISSING/INCOMPLETE/INVALID DESCRIPTION OF SERVICE FOR A NOT OTHERWISE CLASSIFIED (NOC) CODE OR FOR AN UNLISTED/BY REPORT PROCEDURE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
919	HYSTERECTOMY ACKNOWLEDGEMENT OR STERILIZATION CONSENT IS MISSING.	N3	MISSING CONSENT FORM.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
920	THE SERVICE/PROCEDURE BILLED IS NOT A MEDICAID BENEFIT.	N425	STATUTORILY EXCLUDED SERVICE(S).	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

921	STATUTORILY EXCLUDED SERVICE(S).	N425	STATUTORILY EXCLUDED SERVICE(S).	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
922	AMBULANCE SERVICE NEEDS TO BE BILLED TO MENTAL HEALTH CONTRACTOR, MAGELLAN.	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	109	CLAIM/SERVICE NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 | LAST MODIFIED: 01/29/2012...
923	BASED ON MEDICAL REVIEW, THE ASSISTANT AT SURGERY IS NOT MEDICALLY NECESSARY.	N115	THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,...	50	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
924	THE CHARGE IS PART OF THE DRG OF THE FIRST HOSPITAL.	N47	CLAIM CONFLICTS WITH ANOTHER INPATIENT STAY.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
925	NO REASON WAS PROVIDED FOR AN AMBULANCE TRANSFER TO A DIFFERENT HOSPITAL.		...	117	TRANSPORTATION IS ONLY COVERED TO THE CLOSEST FACILITY THAT CAN PROVIDE THE NECESSARY CARE
926	THE DOCUMENTATION SUBMITTED IS NOT LEGIBLE.	N205	INFORMATION PROVIDED WAS ILLEGIBLE.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
927	THIS CHARGE REPRESENTS FRAGMENTED/INCIDENTAL BILLING WITH OTHER CHARGES SUBMITTED.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...

928	DOCUMENTATION INDICATING FETAL STATUS AT THE TIME OF/OR PRIOR TO THE PROCEDURE IS REQUIRED TO REVIEW THIS CLAIM.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
929	THIS SERVICE/PROCEDURE BILLED DOES NOT MEET MEDICARE LCD/NCD GUIDELINES.	N115	THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,...	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
930	SUPPORTING ULTRASOUND DOCUMENTATION IS REQUIRED IN ORDER TO EVALUATE THIS CLAIM.	M60	MISSING CERTIFICATE OF MEDICAL NECESSITY.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
931	THE INCORRECT MODIFIER HAS BEEN USED FOR ASSISTANT AT SURGERY/ASSISTANT SURGEON.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
932	VISUAL FIELD ACUITY TEST, TAPED AND UNTAPED IS MISSING.	N178	MISSING PRE-OPERATIVE IMAGES/VISUAL FIELD RESULTS.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
933	UNITS OF SERVICE EXCEED MEDICALLY UNLIKELY EDIT/MAX UNITS.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

934	SERVICE EXCEEDS FREQUENCY LIMITATIONS.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
935	THE DATE SPAN OF THIS CLAIM OVERLAPS THE DATE SPAN OF THE PREVIOUS PAID CLAIM.	N300	MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
936	THERE IS NO DOCUMENTATION SHOWING MEMBER TRIALED EQUIPMENT AND DOCUMENTED RESULTS.	N223	MISSING DOCUMENTATION OF BENEFIT TO THE PATIENT DURING INITIAL TREATMENT PERIOD.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
937	THE CLAIM REQUIRES THE LENGTH OF THE EXTENSION SET.	M23	MISSING INVOICE.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
938	THERE IS A LIMIT OF ONE CONSULTATION PER PATIENT PER INDIVIDUAL PROVIDER PER 12 MONTHS FOR RELATED CONDITIONS.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
939	TWO SEPARATE PHYSICIANS HAVE BILLED FOR "INITIAL HOSPITAL CARE". ONLY ONE PHYSICIAN IS ALLOWED TO BILL THIS CODE PER HOSPITALIZATION.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

940	THE BILLING INSTRUCTIONS ON THE DHS EXCEPTION LETTER WERE NOT FOLLOWED.	N54	CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
941	A MODIFIER IS REQUIRED WHEN BILLING THIS SERVICE.	N519	INVALID COMBINATION OF HCPCS MODIFIERS.	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
942	CONCURRENT CARE WAS RENDERED. IT DID NOT MEET MEDICAID CRITERIA FOR PAYMENT.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
943	PRIOR AUTHORIZATION FOR THE ITEM/SERVICE BILLED WAS NOT APPROVED.	M62	MISSING/INCOMPLETE/INVALID TREATMENT AUTHORIZATION CODE.	39	SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED
944	THE MEDICAL NEED FOR THE AMBULANCE WAS NOT PROVIDED.	N115	THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,...	50	THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
945	THE MILES WERE REDUCED; THE TRIP WAS NOT TO THE NEAREST APPROPRIATE FACILITY.		...	117	TRANSPORTATION IS ONLY COVERED TO THE CLOSEST FACILITY THAT CAN PROVIDE THE NECESSARY CARE
946	AIR AMBULANCE NEED WAS NOT SHOWN.	N115	THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,...	150	PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE

947	DOCUMENTATION IS NOT COMPLETE.	N705	INCOMPLETE/INVALID DOCUMENTATION.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
948	WARRANTY STATUS IS REQUIRED, PLEASE INCLUDE MAKE/MODEL/PURCHASE DATE.	N150	MISSING/INCOMPLETE/INVALID MODEL NUMBER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
949	FREQUENCY/DURATION/NUMBER OF HOURS PER VISIT FOR THE SERVICE IS REQUIRED	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
950	USE OF THE 22 MODIFIER IS NOT WARRANTED BASED ON REVIEW OF THE DOCUMENTATION PROVIDED.	N519	INVALID COMBINATION OF HCPCS MODIFIERS.	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
951	EXPERIMENTAL SERVICES/PROCEDURES ARE NOT COVERED.	N425	STATUTORILY EXCLUDED SERVICE(S).	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
952	DOCUMENTATION DESCRIBING INCREASED SERVICES IS REQUIRED FOR ADDITIONAL PAYMENT TO BE CONSIDERED.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

953	MANUFACTURER'S INVOICE IS REQUIRED.	M23	MISSING INVOICE.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
954	THERE APPEARS TO BE A MORE SPECIFIC HCPCS/CPT/CDT PROCEDURE/REVENUE CODE THAT DESCRIBES THE ITEM OR SERVICE BILLED.	M81	YOU ARE REQUIRED TO CODE TO THE HIGHEST LEVEL OF SPECIFICITY.	189	'NOT OTHERWISE CLASSIFIED' OR 'UNLISTED' PROCEDURE CODE (CPT/HCPCS) WAS BILLED WHEN THERE IS A SPECIFIC PROCEDURE CODE FOR THIS PROCEDURE/SERVIC
955	OBSTETRICAL CARE MUST BE BILLED AS A GLOBAL FEE.	N525	THESE SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN THE GLOBAL PERIOD OF ANOTHER SERVICE.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
956	PARAGRAPH 1 OR 2 NEEDS CROSSED OUT ON THE CONSENT FORM OR THE INCORRECT PARAGRAPH IS CROSSED OUT.	N28	CONSENT FORM REQUIREMENTS NOT FULFILLED.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
957	A SIGNATURE STAMP IS NOT VALID ON THE CONSENT FORM.	N399	INCOMPLETE/INVALID ELECTIVE CONSENT FORM.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
958	DOCUMENTATION INDICATING DATE OF SURGERY, DATE CPM USE BEGAN, AND/OR DATE OF DISCHARGE IS REQUIRED TO REVIEW THIS CLAIM.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

959	THE SERVICES PROVIDED AND UNITS BILLED DO NOT MATCH.	N430	PROCEDURE CODE IS INCONSISTENT WITH THE UNITS BILLED.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
960	DATES OF SERVICES ARE OUTSIDE THE APPROVED PRIOR AUTHORIZATION DATE SPAN.	N351	SERVICE DATE OUTSIDE OF THE APPROVED TREATMENT PLAN SERVICE DATES.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
961	REQUIRED MEDICAL HISTORY AND PHYSICAL ARE MISSING.	N221	MISSING ADMITTING HISTORY AND PHYSICAL REPORT.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
962	DOCUMENTATION SHOWING DEGREE & DURATION OF SYMPTOMS & PRIOR ATTEMPTS AT CONSERVATIVE TREATMENT IS REQUIRED FOR REVIEW THIS CLAIM.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
963	PROGRESS NOTES ARE MISSING.	N393	MISSING PROGRESS NOTES/REPORT.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
964	THIS ITEM IS NOT PAYABLE IN A NURSING FACILITY/SKILLED NURSING FACILITY.	M97	NOT PAID TO PRACTITIONER WHEN PROVIDED TO PATIENT IN THIS PLACE OF SERVICE. PAYMENT INCLUDED IN THE REIMBURSEMENT ISSUED THE FACILITY.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...

965	RESUBMIT CLAIM WITH PHOTOGRAPHS SUPPORTING MEDICAL NECESSITY (IF AVAILABLE).	N178	MISSING PRE-OPERATIVE IMAGES/VISUAL FIELD RESULTS.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
966	THE REFERENCE PROVIDER NUMBER IS MISSING OR INVALID.	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
967	THE PLACE OF SERVICE FIELD MUST REFLECT THE LOCATION WHERE SERVICE WAS PROVIDED.	M77	MISSING/INCOMPLETE/INVALID/INAPPROPRIATE PLACE OF SERVICE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
968	THE PLAN OF TREATMENT IS MISSING OR IS INVALID FOR SERVICES BILLED.	M135	MISSING/INCOMPLETE/INVALID PLAN OF TREATMENT.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
969	IOWA MEDICAID DOES NOT PROVIDE ADDITIONAL REIMBURSEMENT FOR THE 63 MODIFIER.	N519	INVALID COMBINATION OF HCPCS MODIFIERS.	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
970	DATE SPAN CONFLICTS WITH UNITS BILLED OR DATE SPAN REQUIRED WHEN BILLING THIS SERVICE.	N300	MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN DATE(S).	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

971	AN INCORRECT CONDITION CODE WAS USED.	M44	MISSING/INCOMPLETE/INVALID CONDITION CODE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
972	INCOMPLETE/INVALID DOCUMENTATION/ORDERS/NOTES/SUMMARY/REPORT/CHART.	N705	INCOMPLETE/INVALID DOCUMENTATION.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
973	REPAIR OR REPLACEMENT OF DME IS NOT COVERED.	N171	PAYMENT FOR REPAIR OR REPLACEMENT IS NOT COVERED OR HAS EXCEEDED THE PURCHASE PRICE.	96	NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2...
974	THE PHYSICIAN ORDER IS MISSING.	N455	MISSING PHYSICIAN ORDER.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
975	SERVICE BILLED MUST BE CLEARLY IDENTIFIED ON INVOICE.	N354	INCOMPLETE/INVALID INVOICE.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
976	EQUIPMENT MUST BE PATIENT OWNED.	M124	MISSING INDICATION OF WHETHER THE PATIENT OWNS THE EQUIPMENT THAT REQUIRES THE PART OR SUPPLY.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...

977	INCORRECT CONSENT FORM IS ATTACHED.	N228	INCOMPLETE/INVALID CONSENT FORM.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
978	ADDITIONAL INFORMATION IS REQUIRED.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
979	INCORRECT MODIFIER FOR ITEM OR SERVICE BILLED.	N519	INVALID COMBINATION OF HCPCS MODIFIERS.	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
980	THE NDC IS NOT A REBATABLE NDC.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	211	NATIONAL DRUG CODES (NDC) NOT ELIGIBLE FOR REBATE, ARE NOT COVERED
981	UNITS ON PRIOR AUTHORIZATION WERE EXCEEDED.	N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
982	ITEMS BILLED ARE INCLUDED IN RENTAL FEE.	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
983	DOCUMENTATION WAS NOT VALID FOR DATE(S) OF SERVICE/MEMBER BILLED.	N706	MISSING DOCUMENTATION.	250	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS THE INCORRECT ATTACHMENT/DOCUMENT. THE EXPECTED ATTACHMENT/DOCUMENT IS STILL MISSING. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMIT...

984	AN AMBULANCE RUN REPORT MUST BE SUBMITTED WITH THE CLAIM FORM.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
985	DATE OF X-RAY IS INVALID. CHECK X-RAY DATE FOR VALIDITY UNDER IOWA MEDICAID POLICY.	N326	MISSING/INCOMPLETE/INVALID LAST X-RAY DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
986	DIAGNOSTIC TESTING OR LABORATORY REPORTS ARE REQUIRED TO REVIEW THIS CLAIM.	N395	MISSING LABORATORY REPORT.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)
987	DOCUMENTATION MUST INCLUDE DOSE/STRENGTH OF MEDICATION AND HEIGHT/WEIGHT AND BSA OF MEMBER.	M123	MISSING/INCOMPLETE/INVALID NAME, STRENGTH, OR DOSAGE OF THE DRUG FURNISHED.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
988	PHYSICIAN STATEMENT MUST BE SIGNED BY THE PHYSICIAN WHO PERFORMED THE PROCEDURE. A STAFF SIGNATURE IS NOT ACCEPTABLE.	MA81	MISSING/INCOMPLETE/INVALID PROVIDER/SUPPLIER SIGNATURE.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
989	REQUIRED ABORTION DOCUMENTATION IS MISSING.	N706	MISSING DOCUMENTATION.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)

990	THIS SERVICE IS AN EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM.		...	18	EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
991	THIS SERVICE HAS BEEN INCORRECTLY BILLED MULTIPLE TIMES ON ONE CLAIM FORM FOR THE SAME DATE OF SERVICE.	N390	THIS SERVICE/REPORT CANNOT BE BILLED SEPARATELY.	97	THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT...
992	THERE IS A DISCREPANCY BETWEEN THE DATE OF BIRTH ON THE DOCUMENTATION AND DATE OF BIRTH LISTED IN OUR RECORDS.	N327	MISSING/INCOMPLETE/INVALID OTHER INSURED BIRTH DATE.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
993	THE FACILITY NAME IS MISSING.	N28	CONSENT FORM REQUIREMENTS NOT FULFILLED.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
994	THE OPERATIVE REPORT DOES NOT SUPPORT THE USE OF THE 62 MODIFIER OR MPFS INDICATES THAT CO-SURGEONS ARE NOT PAYABLE FOR THIS PROCEDURE.	N519	INVALID COMBINATION OF HCPCS MODIFIERS.	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
995	THE CLAIM MUST BE BILLED AS TECHNICAL COMPONENT ONLY - WITH MODIFIER TC.		...	4	THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
996	THE SERVICE BILLED DOES NOT MATCH THE ORDER.	N206	THE SUPPORTING DOCUMENTATION DOES NOT MATCH THE INFORMATION SENT ON THE CLAIM.	250	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS THE INCORRECT ATTACHMENT/DOCUMENT. THE EXPECTED ATTACHMENT/DOCUMENT IS STILL MISSING. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMIT...

997	MANUFACTURER'S PRICE INVOICE SUBMITTED IS NOT FOR THE ITEM BILLED.	N354	INCOMPLETE/INVALID INVOICE.	251	THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE...
998	THE BILL TYPE SUBMITTED IS INVALID OR INCORRECT FOR THE BILLING. CONSULT THE MEDICAID BILLING INSTRUCTIONS FOR THE CORRECT TYPE OF BILL.	MA30	MISSING/INCOMPLETE/INVALID TYPE OF BILL.	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT...
999	A PHYSICIAN ORDER SIGNED AND DATED WITHIN THE LAST YEAR OF SERVICE REQUEST IS REQUIRED.	N455	MISSING PHYSICIAN ORDER.	252	AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT)