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	(USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REOUIRES CO
002	PREVIOUSLY PAID CLAIM. MULTIPLE CLAIMS CANNOT BE BILLED WITH OVERLAPPING DATES OR CHARGES FOR A RECIPIENT. THIS SERVICE/PROCEDURE BILLED	N522	DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM.	18	(USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO
003	DOES NOT MEET IOWA MEDICAID HEALTH HOME PROGRAM GUIDELINES. THE PREDICALD SERVICE LIMIT FOR			272	COVERAGE/PROGRAM GUIDELINES WERE NOT MET
004	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	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	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	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

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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
009	THE FIRST PROCEDURE CODE	MATO	ADMISSION DATE.	10	INCONSISTENT WITH THE MODIFIER USED, USAGE: REFER TO THE 835
011	MODIFIER IS NOT A VALID VALUE FOR IOWA MEDICAID. ENTER THE CORRECT MODIFIER AND RESUBMIT THE CLAIM.			4	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	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	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	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

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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	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. CLAIM EXCEEDS THE 12 MONTH TIMELY FILING LIMIT.	M52	MISSING/INCOMPLETE/INVALID "FROM"•DATE(S) OF SERVICE. 	16 29	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT THE TIME LIMIT FOR FILING HAS EXPIRED
- 013	THE RECIPIENT NUMBER 13 MISSING.				EN INED
020	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

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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. LENGTH OF STAY EXCEEDED FOR	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 COVERAGE/PROGRAM GUIDELINES
026	DIAGNOSIS			273	WERE EXCEEDED
027	MULTIPLE/FRAGMENTED METHODS OF ADMINISTRATION HAVE BEEN BILLED.	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	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
	THE MEDICAID MAXIMUM FOR CROWNS IS TWO PER 12 MONTH PERIOD. THIS MAXIMUM HAS BEEN		NOT COVERED MORE THAN ONCE IN		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
028	EXCEEDED.	M90	A 12 MONTH PERIOD.	96	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

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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 THE MAXIMUM NUMBER OF SERVICES	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	ALLOWABLE FOR THE PROCEDURE BILLED HAS BEEN EXCEEDED.			273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
	THE LINE ITEM REVENUE CODE IS		MISSING/INCOMPLETE/INVALID		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
035	MISSING.	M50	REVENUE CODE(S).	16	REMITT
036	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	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	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. THE NUMBER OF SERVICES ALLOWED FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	16 273	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED

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	MISSING OR INVALID. CORRECT THE				
041	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	INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
	THE TOTAL CLAIM CHARGE AMOUNT AND THE SUM OF THE LINE ITEM		MISSING/INCOMPLETE/INVALID		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
044	CHARGES ARE NOT EQUAL.	M54	TOTAL CHARGES.	16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUPMISSION/BILLING
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	OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS 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	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

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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. ONET ONE CONSULTATION IS	N19	PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE.	97	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
	PAYABLE PER RECIPIENT/PER				
051	PROVIDER. SUBSEQUENT CONSULTATIONS MUST BE BILLED AS OFFICE/HOSPITAL VISITS.			273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
	THE SERVICE LIMIT FOR THIS EXCEPTION TO POLICY SERVICE HAS				COVERAGE/PROGRAM GUIDELINES
052	BEEN EXCEEDED. THE NUMBER OF TREATMENTS			273	WERE EXCEEDED
053	EXCEEDS THE MAXIMUM NUMBER ALLOWED BY MEDICAID. ANY ONE OF THE LINE ITEM			273	COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED
054	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	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

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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	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	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

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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

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					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
	THE 2ND SURGICAL PROCEDURE				DOCUMENTATION. AT LEAST ONE
	CODE DOES NOT HAVE A VALID				REMARK CODE MUST BE PROVIDED
	SURGICAL DATE. RESUBMIT THE				(MAY BE COMPRISED OF EITHER THE
071	CLAIM WITH THE CORRECT SECOND	NOOO	MISSING/INCOMPLETE/INVALID	16	NCPDP REJECT REASON CODE, OR
071	SURGICAL PROCEDURE DATE.	N302	OTHER PROCEDURE DATE(S).	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
	THE 3RD SURGICAL PROCEDURE				DOCUMENTATION. AT LEAST ONE
	CODE DOES NOT HAVE A VALID				REMARK CODE MUST BE PROVIDED
	SURGICAL DATE. RESUBMIT THE				(MAY BE COMPRISED OF EITHER THE
	CLAIM WITH THE CORRECT THIRD		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
072	SURGICAL PROCEDURE DATE.	N302	OTHER PROCEDURE DATE(S).	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
	THE 4TH SURGICAL PROCEDURE				DOCUMENTATION. AT LEAST ONE
	CODE DOES NOT HAVE A VALID				REMARK CODE MUST BE PROVIDED
	SURGICAL DATE. RESUBMIT THE		MICCINIC /INICOMDI ETE /INIVALID		(MAY BE COMPRISED OF EITHER THE
073	CLAIM WITH THE CORRECT FOURTH SURGICAL PROCEDURE DATE.	N302	MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S).	16	NCPDP REJECT REASON CODE, OR REMITT
0/3	SURGICAL PROCEDURE DATE.	11302	OTHER PROCEDURE DATE(3):	10	
					CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
	5TH DIAGNOSIS INCORRECT AS				(MAY BE COMPRISED OF EITHER THE
	SUBMITTED. PLEAS CORRECT AND		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
074	RESUBMIT CLAIM.	M76	DIAGNOSIS OR CONDITION.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
	THE ETH CHROTON PROCEDURE				ATTACHMENT(S)/OTHER
	THE 5TH SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID				DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED
	SURGICAL DATE. RESUBMIT THE				(MAY BE COMPRISED OF EITHER THE
	CLAIM WITH THE CORRECT FIFTH		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
075	SURGICAL PROCEDURE DATE.	N302	OTHER PROCEDURE DATE(S).	16	REMITT
<u> </u>					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
			MISSING/INCOMPLETE/INVALID		(MAY BE COMPRISED OF EITHER THE
	THE REFERRING PROVIDER NUMBER		REFERRING PROVIDER PRIMARY		NCPDP REJECT REASON CODE, OR
076	IS ZEROES.	N286	IDENTIFIER.	16	REMITT

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	THE SURGICAL PROCEDURE CODE				CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE
	DOES NOT HAVE A VALID SURGICAL				REMARK CODE MUST BE PROVIDED
	DATE RESUBMIT THE CLAIM WITH				(MAY BE COMPRISED OF EITHER THE
	THE CORRECT SURGICAL PROCEDURE		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
077	DATE.	N302	OTHER PROCEDURE DATE(S).	16	REMITT
	THE NUMBER OF DAYS BILLED DO				CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED
	NOT MATCH THE FIRST DATE OF				(MAY BE COMPRISED OF EITHER THE
	SERVICE THROUGH THE LAST DATE		DATE RANGE NOT VALID WITH UNITS		NCPDP REJECT REASON CODE, OR
078	OF SERVICE.	N345	SUBMITTED.	16	REMITT COVERAGE/PROGRAM GUIDELINES
079	MAXIMUM LIMIT EXCEEDED.			273	WERE EXCEEDED
0.0					NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF
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	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. ONLY ONE MEDICAL CASE	N479	MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER). THE NUMBER OF DAYS OR UNITS OF	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT BENEFIT MAXIMUM FOR THIS TIME
	MANAGEMENT IS ALLOWED PER		SERVICE EXCEEDS OUR ACCEPTABLE		PERIOD OR OCCURRENCE HAS BEEN
082	CALENDAR MONTH.	N362	MAXIMUM.	119	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	NOT MET. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
084	ARE PAYABLE PER 12 MONTH PERIOD (ONE PER MONTH). THIS NUMBER HAS BEEN EXCEEDED. THE RECIPIENT 1D NUMBER IS NOT	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	ON FILE. THE CLAIM MUST BE RESUBMITTED WITH THE CORRECT RECIPIENT ID NUMBER.			31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED

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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	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	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	(ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
089	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	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. THE SERVICE LIMIT MAXIMUM HAS BEEN EXCEEDED.			133 273	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 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

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	THE MEDICALD SERVICE LIMIT FOR				
	THIS SERVICE HAS BEEN EXCEEDED.				
	IF UNUSUAL CIRCUMSTANCES ARE				
	DOCUMENTED, MEDICAL REVIEW CAN				COVERAGE/PROGRAM GUIDELINES
095	BE REQUESTED.			273	WERE EXCEEDED
093	DE REQUESTED.			2/3	
					NON-COVERED CHARGE(S). AT LEAST
					ONE REMARK CODE MUST BE
					PROVIDED (MAY BE COMPRISED OF
					EITHER THE NCPDP REJECT REASON
	THE RECIPIENT IS NOT ELIGIBLE FOR				CODE, OR REMITTANCE ADVICE
	FULL MEDICAID COVERAGE.				REMARK CODE THAT IS NOT AN
	ELIGIBILITY IS FOR				ALERT.) USAGE: REFER TO THE 835
	COINSURANCE/DEDUCTIBLE ON		PATIENT INELIGIBLE FOR THIS		HEALTHCARE POLICY
096	MEDICARE-COVERED SERVICES.	N30	SERVICE.	96	IDENTIFICATION SEGMENT (LOOP 2
050	TIEBIC/WE COVERED SERVICES.	1130	JERVICE.	30	,
					NON-COVERED CHARGE(S). AT LEAST
					ONE REMARK CODE MUST BE
					PROVIDED (MAY BE COMPRISED OF
					EITHER THE NCPDP REJECT REASON
	SERVICE NOT COVERED FOR				CODE, OR REMITTANCE ADVICE
	RECIPIENT. THE STATE ELIGIBILITY				REMARK CODE THAT IS NOT AN
	FILE SHOWS LIMITED OR NO				ALERT.) USAGE: REFER TO THE 835
	MEDICAID ELIGIBILITY FOR THE		PATIENT INELIGIBLE FOR THIS		HEALTHCARE POLICY
097	DATE OF SERVICE.	N30	SERVICE.	96	IDENTIFICATION SEGMENT (LOOP 2
	THE RECIPIENT IS IN THE LOCK-IN				
	PROGRAM. THE BILLING PROVIDER IS				SERVICES NOT PROVIDED BY
	NOT AUTHORIZED TO PROVIDE				NETWORK/PRIMARY CARE
098	SERVICES.			242	PROVIDERS
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
					(MAY BE COMPRISED OF EITHER THE
	INVALID ICD-10 PRINCIPAL		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
099	DIAGNOSIS CODE	MA63	PRINCIPAL DIAGNOSIS.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
	DIAGNOSIS BILLEDIS NOT A REASON				DOCUMENTATION, AT LEAST ONE
	FOR HOSPITAL SERVICE BASED ON				REMARK CODE MUST BE PROVIDED
	APG/DRG GROUPER, DIAGNOSIS				(MAY BE COMPRISED OF EITHER THE
	-,		MICCINC/INCOMPLETE/INVALID		`
100	BILLED MUST BE 5 DIGIT CODE IF 5 DIGITS ARE AVAILABLE	M76	MISSING/INCOMPLETE/INVALID	16	NCPDP REJECT REASON CODE, OR REMITT
100	DIGITS ARE AVAILABLE	M76	DIAGNOSIS OR CONDITION.	16	
					CLAIM/SERVICE LACKS INFORMATION
1					OR HAS SUBMISSION/BILLING
1					ERROR(S). USAGE: DO NOT USE THIS
1					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
	THE REFERRING PROVIDER NUMBER				DOCUMENTATION. AT LEAST ONE
	IS NOT A VALID MEDICAID PROVIDER				REMARK CODE MUST BE PROVIDED
	NUMBER OR HAS BEEN TERMED BY		MISSING/INCOMPLETE/INVALID		(MAY BE COMPRISED OF EITHER THE
1	THE MEDICAID AUTHORITY FOR THE		REFERRING PROVIDER PRIMARY		NCPDP REJECT REASON CODE, OR
101	DATE OF SERVICE.	N286	IDENTIFIER.	16	REMITT
					·

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			LOD CIOSSWalk		
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	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	(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

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	REIMBURSEMENT HAS NOT BEEN				PRECERTIFICATION/AUTHORIZATION
	AUTHORIZED FOR THE SERVICE				/NOTIFICATION/PRE-TREATMENT
109	BILLED.			197	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	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.	В7	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	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	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	INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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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	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. THE BILLING PROVIDER NUMBER IS NOT ON THE PROVIDER MASTER	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 NATIONAL PROVIDER IDENTIFIER -
121	FILE.			208	NOT MATCHED WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP
122	THIS IS AN EPSDT DIAGNOSIS CODE AND THE RECIPIENT IS 21 OR OLDER.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER
123	THE QUANTITY DISPENSED FOR THE NDC IS BELOW THE MINIMUM QUANTITY.	N378	MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY.	16	DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT

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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	(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	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	(ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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					THE TROCEDORE CODE 10
131	MODIFIER FOR PROCEDURE CODE IS INVALID FOR HOSPITAL PLACE OF SERVICE.			4	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	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	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	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
			HEALTH CARE POLICY COVERAGE IS		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
137	CARRIER DENIED COVERAGE.	N598	PRIMARY.	16	REMITT

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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
	THE NDC IS NOT A VALID NDC FOR		MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
141	THE 1ST PROCEDURE CODE MODIFIER IS NOT VALID WITH THE PROCEDURE CODE BILLED.	M119	NATIONAL DRUG CODE (NDC).	16	INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT
143	THE 2ND PROCEDURE CODE MODIFIER IS NOT VALID FOR THE PROCEDURE CODE BILLED.			4	INFORMATION REF), IF PRESENT 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	INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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					THE DIMONDER OF THE DIAGNOSTIC TO THE DIAGNOSTIC
145	THE DIAGNOSIS AND PROCEDURE BILLED ARE NOT COMPATIBLE. THE DIAGNOSIS MUST REFLECT THE MEDICAL NEED FOR THE PROCEDURE BILLED.			11	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	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	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	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

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					DOCUMENTATION IS REQUIRED TO
152	PROCEDURE CODE AND/OR MODIFIER SUBMITTED REQUIRE MANUAL PRICING. INSUFFICIENT DATA WAS PROVIDED TO ALLOW A PRICING DETERMINATION.	N706	MISSING DOCUMENTATION.	252	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. THE MAXIMUM NUMBER OF SERVICES	N2 4 5	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	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
	A PROVIDER PAYMENT RATE WAS NOT FOUND FOR THE DATE OF SERVICE. PLEASE CONTACT PROVIDER SERVICES FOR		PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
157	ASSISTANCE.	N65	SERVICE/PROVIDER.	16	REMITT CLAIM/SERVICE LACKS INFORMATION
158	THE TREATING PROVIDER NUMBER IS NOT A VALID MEDICAID BILLING NUMBER.	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER.	16	OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT

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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/INAP PROPRIATE 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. ALLOWANCE FOR SURGICAL TRAY HAS BEEN ADDED	N570	MISSING/INCOMPLETE/INVALID CREDENTIALING DATA. 	B7 70	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 COST OUTLIER - ADJUSTMENT TO COMPENSATE FOR ADDITIONAL COSTS

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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/INAP PROPRIATE 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

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172	THE RECIPIENT'S AGE IS NOT WITHIN THE AGE RANGE ALLOWED FOR THE PROCEDURE CODE.			6	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	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	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	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

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	1			ı	THE TROOLDORLINGE CODE TO
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	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	(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	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	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	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	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

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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
					(ARE) NOT COVERED. USAGE: REFER
189	THE SECOND DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	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	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	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	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	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	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	(ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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		1	1		,
197	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	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	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.	NOOI	NECESSART.	9	INFORMATION REF), IF PRESENT 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	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	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	(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	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)

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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	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	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 CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS
209	THE PLACE OF SERVICE BILLED IS NOT A VALID PLACE OF SERVICE FOR PHYSICIAN ASSISTANT SERVICES.	M77	MISSING/INCOMPLETE/INVALID/INAP PROPRIATE PLACE OF SERVICE.	16	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	(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	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)

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					DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT
	THE 3RD DIAGNOSIS CODE REQUIRES				REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT
212	MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	AN ALERT)
213	DUPLICATE CASE MANAGEMENT SERVICES WERE RECEIVED FOR THE CALENDAR MONTH.			18	(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	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
					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
215	THE 4TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	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	(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	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	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)

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					THE DIAGROSIS IS INCONSISTENT
220	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE SIXTH DIAGNOSIS CODE.			9	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	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	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	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	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	WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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			1		111E D1/10/10010 10 1/100/1010 E/11
228	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SEVENTH DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT PRECENTIFICATION/AUTHORIZATION
229	THE PRIOR AUTHORIZATION REASON CODE IS MISSING OR NOT ON FILE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	197	/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. INVALID OR MISSING PATIENT MANAGER REFERRAL NUMBER FOR THIS RECIPIENT.	N517 N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	197 197	PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT ABSENT PRECERTIFICATION/AUTHORIZATION /NOTIFICATION/PRE-TREATMENT ABSENT
232	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	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	/NOTIFICATION/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	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	PRIOR AUTHORIZATION. THE DATE OF SERVICE ON THE CLAIM ARE NOT WITHIN THE DATE RANGE OF THE PRIOR AUTHORIZATION. THE PROCEDURE CODE REQUIRES A	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	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

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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 PRECERTIFICATION/NOTIFICATION/A
241	THE PRIOR AUTHORIZATION HAS BEEN USED.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	198	UTHORIZATION/PRE-TREATMENT EXCEEDED
2.11	THE RECIPIENT IS 65 OR OLDER AND NO MEDICARE COVERAGE IS	11317	MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
242	PRESENT ON THE RECIPIENT FILE.	N479	MEDICARE SECONDARY PAYER).	16	REMITT
	IOWA MEDICAID HAS NOT ESTABLISHED A FEE FOR THIS PROCEDURE AND THE ALLOWED AMOUNT ON THE PRIOR		PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
243	AUTHORIZATION IS ZERO.	N65	SERVICE/PROVIDER.	16	REMITT
244	THE 8TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW .	N706	MISSING DOCUMENTATION.	252	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

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	ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS				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
248	MISSING OR INCOMPLETE.	N3	MISSING CONSENT FORM.	252	AN ALERT)
249	MORE THAN 20 CLAIMS HAVE BEEN SUBMITTED FOR THIS RECIPIENT, CLAIMS WILL BE PROCEESSED IN THE NEXT CYCLE.			133	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
	OF SERVICE ON CLAIM. TYPE OF BILL				
250	OR DIAGNOSIS/PROCEDURE CODE(S) MAY BE INVALID.			A8	UNGROUPABLE DRG
250	THE RECIPIENT NUMBER 13 NOT ON			Að	UNGROUPABLE DRG
251	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
253	ON THE DIAGNOSIS FILE.	14170	DIAGNOSIS OR CONDITION.	10	THIS (THESE) DIAGNOSIS(ES) IS
254	THE NINTH DIAGNOSIS CODE IS NOT COVERED BY MEDICAID.	N30	PATIENT INELIGIBLE FOR THIS SERVICE.	167	(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	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)

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256	THE RECIPIENT HAS MEDICARE COVERAGE ACCORDING TO DHS RECORDS. MEDICARE MUST BE BILLED FOR THE SERVICE. MEDICAID WILL PAY CROSS-OVER CLAIM ONLY THE RECIPIENT'S AGE IS NOT	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 WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT
257	ALLOWED FOR THE NINTH DIAGNOSIS CODE.			9	(LOOP 2110 SERVICE PAYMENT
257	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE NINTH DIAGNOSIS CODE.	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	INFORMATION REF), IF PRESENT 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	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	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)

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263	ABORTIONS, STERILIZATIONS, AND HYSTERECTOMIES MUST BE SUBMITTED WITH PROPER DOCUMENTATION FOR MANUAL REVIEW.	N66	MISSING/INCOMPLETE/INVALID DOCUMENTATION.	252	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	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	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 INCLIGIBLE 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

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					THE TROOLDONE/ NETEROL CODE TO
272	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SECOND SURGICAL PROCEDURE CODE.			7	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	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	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	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

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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	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)
					EXACT DUPLICATE CLAIM/SERVICE
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	(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	INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT EXACT DOFELICATE CLASIFY SERVICE
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	(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	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)

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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 INCONSISTENT WITH THE PATIENT'S
289	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FIFTH SURGICAL PROCEDURE CODE.			6	AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REP, IF PRESENT
290	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FIFTH SURGICAL PROCEDURE CODE.			7	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	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	(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	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

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296	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SIXTH SURGICAL PROCEDURE CODE.			7	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	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	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	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) THE DAYS SUPPLIED EXCEEDS THE MAXIMUM ALLOWED.	N34	INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE. 	16 273	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT 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

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	T				TATTIENT TO DELIZED TATIENT
304	YOUR LICENSE HAS EXPIRED. PLEASE SEND COPY OF CURRENT RENEWAL.	M143	THE PROVIDER MUST UPDATE LICENSE INFORMATION WITH THE PAYER.	170	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. DRG NOT ON FILE.	M144	PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE.	97 A8	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 UNGROUPABLE DRG
310	THE ADJUSTMENT TON 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

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			THE NUMBER OF DAYS OR UNITS OF		BENEFIT MAXIMUM FOR THIS TIME
312	UNITS EXCEEDED MAXIMUM UNITS ALLOWED FOR PARTIAL HOSPITAL.	N362	SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	PERIOD OR OCCURRENCE HAS BEEN REACHED
	UNITS SUBMITTED EXCEED THE MAXIMUM UNITS ALLOWED FOR DAY		THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE		BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN
313	TREATMENT.	N362	MAXIMUM.	119	REACHED
314	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
	NO APG WEIGHT ASSIGNED FOR		PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
316	PROCEDURE BILLED.	N65	SERVICE/PROVIDER.	16	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.		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 CLAIM/SERVICE LACKS INFORMATION
320	THE CONDITION CODE BILLED IS NOT A VALID CONDITION CODE PER UB 04 MANUAL.	M44	MISSING/INCOMPLETE/INVALID CONDITION CODE.	16	OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT

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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.	В7	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	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	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	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	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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32'	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
33	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
33	THE CLAIM DATE OF SERVICE IS TOO OLD TO PROCESS. TIMELY FILING GUIDELINES WERE NOT MET.			29	THE TIME LIMIT FOR FILING HAS EXPIRED
33.		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
33	BILLED WITHIN 72 HOURS OF AN INPATIENT CLAIM FROM THE SAME FACILITY. CHARGES MUST BE COMBINED.			60	SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN A PERIOD OF TIME PRIOR TO OR AFTER INPATIENT SERVICES
33	PROVIDER IS INELIGIBLE TO BILL FOR SPECIAL CHILD ABUSE 4 PROCEDURE CODES.	N570	MISSING/INCOMPLETE/INVALID CREDENTIALING DATA.	B7	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
	THE CLAIM EXCEEDS THE LINE ITEM		REBILL SERVICES ON SEPARATE		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
33		N61	CLAIMS.	96	IDENTIFICATION SEGMENT (LOOP 2

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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	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	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	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	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

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OR HAS SUBMISSION/BILLII ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. THAT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. THAT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. THAT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. THAT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. THAT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PRO						
EXCEEDED. IF UNUSUAL CIRCUMSTANCES ARE DOCUMENTED, MEDICAL REVIEW CAN BE REQUESTED. N435 DOCUMENTATION. 119 BENEFIT MAXIMUM FOR THIS PERIOD OR OCCURRENCE HAS REACHED CLAIM/SERVICE LACKS INFORM OR HAS SUBMISSION/BILLI ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. MEMBER IS NOT CERTIFIED FOR HOSPICE SERVICE MEMBER IS NOT CERTIFIED FOR OCCURRENCE SPAN CODE(S). MEMBER IS NOT CERTIFIED FOR HOSPICE SERVICE M46 OCCURRENCE SPAN CODE(S). MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN CODE(S). MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN CODE(S). CLAIM/SERVICE LACKS INFORM OR HAS SUBMISSION/BILLI ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. CLAIM/SERVICE LACKS INFORM OR HAS SUBMISSION/BILLI ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE NCPDP REJECT REASON CODE (MAY BE COMPRISED OF EITHE NCPDP REJECT REASON CODE REMITT CLAIM/SERVICE LACKS INFORM OR HAS SUBMISSION/BILLI ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE NCPDP REJECT REASON CODE REMITT CLAIM/SERVICE LACKS INFORM OR HAS SUBMISSION/BILLI ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS OF THE PROVIDE OF THE NOT THE PROV	343	MEMBER DOES NOT HAVE MEDICARE.	N34	,	16	ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
MEMBER IS NOT CERTIFIED FOR M46 MISSING/INCOMPLETE/INVALID NC PREVENUE CODE 001 MUST BE SUBMITTED ON LINE 23 OF UB04 M50 REVENUE CODE(S). OR HAS SUBMISSION/BILLII ERROR(S), USAGE: DO NOT USI CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE NCPDP REJECT REASON CODE REMITT CLAIM/SERVICE LACKS INFORM OR HAS SUBMISSION/BILLII ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE NCPDP REJECT REASON CODE REMITT REV CODE 001 MUST BE SUBMITTED ON LINE 23 OF UB04 M50 REVENUE CODE(S). 16 REMITT CLAIM/SERVICE LACKS INFORM NCPDP REJECT REASON CODE REMITT CLAIM/SERVICE LACKS INFORM OR HAS SUBMISSION/BILLII ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS	344	EXCEEDED. IF UNUSUAL CIRCUMSTANCES ARE DOCUMENTED, MEDICAL REVIEW CAN BE	N435	APPROVED /ALLOWED WITHIN TIME PERIOD WITHOUT SUPPORT	119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
OR HAS SUBMISSION/BILLII ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE NCPDP REJECT REASON CODE REMITT A REV CODE 001 MUST BS SUBMITTED ON LINE 23 OF UB04 M50 REVENUE CODE(S). 16 CLAIM/SERVICE LACKS INFORM OR HAS SUBMISSION/BILLII ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS	345		M46		16	ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
OR HAS SUBMISSION/BILLII ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS	346		M50	The state of the s	16	ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
THE REVENUE CODE BILLED IS NOT A VALID REVENUE CODE AS SHOWN IN THE UB04 BILLING MANUAL OR THE DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV (MAY BE COMPRISED OF EITHE	347	VALID REVENUE CODE AS SHOWN IN THE UB04 BILLING MANUAL OR THE REVEUNE CODE IS NOT ALLOWED	M50	MISSING/INCOMPLETE/INVALID		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
OR HAS SUBMISSION/BILLII ERROR(S). USAGE: DO NOT USI CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST REMARK CODE MUST BE PROV		MEDICARE EXHAUST DATE WITH		BEGINNING AND ENDING DATES OF		ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
MEDICARE EXHAUST DATE WITH BEGINNING AND ENDING DATES OF NCPDP REJECT REASON CODE	348	BILLNG DATE. THE SERVICE LIMIT FOR THIS ITEM	MA31	THE PERIOD BILLED.	16	REMITT COVERAGE/PROGRAM GUIDELINES
MEDICARE EXHAUST DATE WITH 348 BILLING DATE. BEGINNING AND ENDING DATES OF THE PERIOD BILLED. NCPDP REJECT REASON CODE REMITT	349	OR SERVICE HAS BEEN EXCEEDED.			273	WERE EXCEEDED

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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	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	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	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	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	THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 LAST MODIFIED: 01/29/2012

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	MISSING OR INCOMPLETE				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
359	DOCUMENTATION	N706	MISSING DOCUMENTATION.	252	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
			DOCUMENTS/GUIDELINES FOR		BENEFIT MAXIMUM FOR THIS TIME
361	SERVICE LIMIT EXCEEDED FOR BILLED SERVICE. MOULTIPLE DENTAL EXAMS HAVE BEEN	N130	INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	119	PERIOD OR OCCURRENCE HAS BEEN REACHED
362	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	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	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

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	T	1		I	
	THE SERVICE LIMIT FOR THIS				
	PROCEDURE HAS BEEN EXCEEDED. IF				
	PROSTHETIC WAS LOST, STOLEN, OR				
	BROKEN BEYOND REPAIR, THIS MUST				COVERAGE/PROGRAM GUIDELINES
367	BE DOCUCMENTED.			273	WERE EXCEEDED
	CLAIM DATE OF SERVICE EXCEEDS				THE TIME LIMIT FOR FILING HAS
368	TIMELY FILING LIMITS.			29	EXPIRED
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION, AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
			MISSING/INCOMPLETE/INVALID		(MAY BE COMPRISED OF EITHER THE
			PATIENT OR AUTHORIZED		NCPDP REJECT REASON CODE, OR
369	NO GUARDIAN RECORD ON FILE.	MA75	REPRESENTATIVE SIGNATURE.	16	REMITT
					EXACT DUPLICATE CLAIM/SERVICE
					(USE ONLY WITH GROUP CODE OA
1	OXYGEN HAS BEEN PREVIOUSLY				EXCEPT WHERE STATE WORKERS'
	BILLED FOR THE SAME OR				COMPENSATION REGULATIONS
370	OVERLAPPING SERVICE DATES.			18	REQUIRES CO
					NON-COVERED CHARGE(S). AT LEAST
					ONE REMARK CODE MUST BE
					PROVIDED (MAY BE COMPRISED OF
					EITHER THE NCPDP REJECT REASON
	THIS BILLING EXCEEDS THE				CODE, OR REMITTANCE ADVICE
	MAXIMUM ALLOWED FOR DME				REMARK CODE THAT IS NOT AN
	RENTAL - EITHER MULTIPLE RENTALS		BILLING EXCEEDS THE RENTAL		ALERT.) USAGE: REFER TO THE 835
	PER MONTH OR RENTAL EXCEEDS		MONTHS COVERED/APPROVED BY		HEALTHCARE POLICY
372	100% OF PURCHASE PRICE.	N370	THE PAYER.	96	IDENTIFICATION SEGMENT (LOOP 2
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
	THE SERVICE BILLED ON THIS LINE				DOCUMENTATION. AT LEAST ONE
	REPRESENT A CHARGE NOT COVERED				REMARK CODE MUST BE PROVIDED
	BY MEDICARE. COVERED SERVICES				(MAY BE COMPRISED OF EITHER THE
l	MUST BE BILLED ON A MEDICAID		INCORRECT CLAIM FORM/FORMAT		NCPDP REJECT REASON CODE, OR
374	CLAIM.	N34	FOR THIS SERVICE.	16	REMITT
					INCONSISTENT WITH THE PATIENT'S
					AGE. USAGE: REFER TO THE 835
					HEALTHCARE POLICY
1	THE RECIPIENT'S AGE IS OUTSIDE				IDENTIFICATION SEGMENT (LOOP
	THE COVERED AGE RANGE FOR		NOT ELIGIBLE DUE TO THE		2110 SERVICE PAYMENT
376	MENTAL HEALTH INSTITUTES.	N129	PATIENT'S AGE.	6	INFORMATION REF), IF PRESENT
					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
1					REMARK CODE THAT IS NOT AN
			THE NUMBER OF DAYS OR UNITS OF		ALERT.) USAGE: REFER TO THE 835
1	THE COVERED DAYS FOR PMIC OR		SERVICE EXCEEDS OUR ACCEPTABLE		HEALTHCARE POLICY
377	MHI IS GREATER THAN 31 DAYS.	N362	MAXIMUM.	96	IDENTIFICATION SEGMENT (LOOP 2
	1		I	<u> </u>	

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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	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 CLAIM/SERVICE LACKS INFORMATION
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	OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS 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	PERIOD OR OCCURRENCE HAS BEEN REACHED
388	THE WRONG CIRCUMCISION CODE WAS BILLED FOR A NEWBORN INFANT.			6	INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
389	CLAIM IS NOT ON FILE. CORRECT RECIPIENT ID NUMBER AND RESUBMIT YOUR CLAIM.			31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED

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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
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	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	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	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	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

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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 CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER
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	DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT
400	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 CHARGES ARE COVERED UNDER A
401	THIS SERVICE IS COVERED BY IOWA PLAN.			24	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. THE NUMBER OF UNITS ALLOWED FOR THIS SERVICE HAS BEEN EXCEEDED.	N20 N362	SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE. THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	97	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 BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED

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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
407	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	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	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	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

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CONCURRENT (FOR EXAMPL OR DIAGI CONCURRENT REFER TO TO POLICY IDENT MULTIPLE PROCEDURE PAYMENT CONCURRENT (FOR EXAMPL OR DIAGI CONCURRENT (LOOP 2110	ASED ON MULTIPLE OR T PROCEDURE RULES. LE MULTIPLE SURGERY NOSTIC IMAGING, ANESTHESIA.) USAGE: HE 835 HEALTHCARE
	TIFICATION SEGMENT D SERVICE PAYMENT TION REF), IF PR
OR HAS SUERROR(S). USA CODE ATTACH POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON- COVERED CHARGES AND/OR NON- COVERED CHARGES AND/OR NON- COVERED DAYS DURING THE BILLING OR HAS SUERROR	E LACKS INFORMATION JBMISSION/BILLING AGE: DO NOT USE THIS E FOR CLAIMS HMENT(S)/OTHER ATION. AT LEAST ONE DE MUST BE PROVIDED PRISED OF EITHER THE CT REASON CODE, OR REMITT
PAYMENT/ALLC SERVICE/PR ALREADY B FRAGMENTED SERVICES HAVE BEEN BILLED ON THIS DATE. THE DENIED SERVICE IS CONSIDERED PART OF THE PREVIOUSLY PAID MEDICAL PROCEDURE CODE INCIDENTAL TO 2110 SE	UDED IN THE DWANCE FOR ANOTHER ROCEDURE THAT HAS BEEN ADJUDICATED. REFER TO THE 835 THCARE POLICY FION SEGMENT (LOOP ERVICE PAYMENT IN REF), IF PRESENT
ONE REMA PROVIDED (M EITHER THE N CODE, OR R REMARK CO ALERT.) USAG THE LEAVE DAYS BILLED EXCEED THE BED HOLD OR LEAVE DAYS HEALT	O CHARGE(S). AT LEAST ARK CODE MUST BE MAY BE COMPRISED OF NCPDP REJECT REASON REMITTANCE ADVICE DOE THAT IS NOT AN GE: REFER TO THE 835 THCARE POLICY ON SEGMENT (LOOP 2
NON-COVERED ONE REMA PROVIDED (M EITHER THE N CODE, OR R REMARK CO ALERT.) USAG THE LEAVE DAYS BILLED EXCEED THE BED HOLD OR LEAVE DAYS HEALT	D CHARGE(S). AT LEAST ARK CODE MUST BE MAY BE COMPRISED OF NCPDP REJECT REASON REMITTANCE ADVICE DOE THAT IS NOT AN GE: REFER TO THE 835 THCARE POLICY ON SEGMENT (LOOP 2
INCL PAYMENT/ALLC SERVICE/PR TIME FRAME REQUIREMENTS BETWEEN THIS ONLY ONE CHARGE FOR DELIVERY SERVICE CAN BE BILLED IN A NINE MONTH PERIOD. OB CARE HAS BEEN MONTH PERIOD. OB CARE HAS BEEN PREVIOUSLY PAID. N357 NOT BEEN MET. 97 INCL PAYMENT/ALLC SERVICE/PRO SERVICE/PRO SERVICE/PROCEDURE/SUPPLY AND A RELATED SERVICE/PROCEDURE/SUPPLY HAVE 2110 SERVICE/PROCEDURE/SUPPLY HAVE 97 INFORMATIO	LUDED IN THE DWANCE FOR ANOTHER ROCEDURE THAT HAS BEEN ADJUDICATED. REFER TO THE 835 THCARE POLICY FION SEGMENT (LOOP ERVICE PAYMENT IN REF), IF PRESENT
ONLY ONE COLLECTION/HANDLING THE NUMBER OF DAYS OR UNITS OF BENEFIT MAX SERVICE EXCEEDS OUR ACCEPTABLE PERIOD OR OF	CIMUM FOR THIS TIME CCURRENCE HAS BEEN REACHED

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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
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
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	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
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	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
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
WITHIN THREE YEARS OF PREVIOUS NEW PATIENT VISIT BY SAME PROVIDER. AN ESTABLISHED PATIENT VISIT MUST BE BILLED. HOME HEALTH SERVICE IS NOT INTERMITTENT AND DOES NOT MEET	N367	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE	B16	'NEW PATIENT' QUALIFICATIONS WERE NOT MET BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
	POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON- COVERED CHARGES AND/OR NON- COVERED DAYS. REFER TO IL THE LAB TESTS BILLED ARE CONSIDERED FRAGMENTED. THE REIMBURSEMENT FOR THIS TEST IS INCLUDED WITH OTHER LAB WORK PREVIOUSLY PAID. MULTIPLE OR FRAGMENTED DENTAL VISITS WERE BILLED FOR THIS DATE OF SERVICE. THE TREATING PROVIDER IS NOT A MEMBER OF THE GROUP THAT IS BILLING. NEW PATIENT VISIT NOT ALLOWED WITHIN THREE YEARS OF PREVIOUS NEW PATIENT VISIT BY SAME PROVIDER. AN ESTABLISHED PATIENT VISIT MUST BE BILLED. HOME HEALTH SERVICE IS NOT	POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON- COVERED CHARGES AND/OR NON- COVERED DAYS. REFER TO IL THE LAB TESTS BILLED ARE CONSIDERED FRAGMENTED. THE REIMBURSEMENT FOR THIS TEST IS INCLUDED WITH OTHER LAB WORK PREVIOUSLY PAID. M80 MULTIPLE OR FRAGMENTED DENTAL VISITS WERE BILLED FOR THIS DATE OF SERVICE. M80 THE TREATING PROVIDER IS NOT A MEMBER OF THE GROUP THAT IS BILLING. NEW PATIENT VISIT NOT ALLOWED WITHIN THREE YEARS OF PREVIOUS NEW PATIENT VISIT BY SAME PROVIDER. AN ESTABLISHED PATIENT VISIT MUST BE BILLED. HOME HEALTH SERVICE IS NOT INTERMITTENT AND DOES NOT MEET	POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON- COVERED CHARGES AND/OR NON- COVERED DAYS. REFER TO II. THE LAB TESTS BILLED ARE CONSIDERED FRAGMENTED. THE REIMBURSEMENT FOR THIS TEST IS INCLUDED WITH OTHER LAB WORK PREVIOUSLY PAID. MULTIPLE OR FRAGMENTED DENTAL VISITS WERE BILLED FOR THIS DATE OF SERVICE. M80 THE TREATING PROVIDER IS NOT A MEMBER OF THE GROUP THAT IS BILLING. NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT. NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT. PROCEDURES FOR BILLING WITH GROUP/REFERRING/PERFORMING PROVIDERS WERE NOT FOLLOWED. WITHIN THREE YEARS OF PREVIOUS NEW PATIENT VISIT BY SAME PROVIDER. AN ESTABLISHED PATIENT VISIT MUST BE BILLED. PATIENT VISIT MUST BE BILLED. HOME HEALTH SERVICE IS NOT INTERMITTENT AND DOES NOT MEET THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE	POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON- COVERED CHARGES AND/OR NON- COVERED CHARGES AND/OR NON- COVERED DAYS. REFER TO IL THE LAB TESTS BILLED ARE CONSIDERED FRAGMENTED. THE REIMBURSEMENT FOR THIS TEST IS INCLUDED WITH OTHER LAB WORK PREVIOUSLY PAID. MISSING/INCOMPLETE/INVALID NON- COVERED DAYS DURING THE BILLING PERIOD. 16 NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT. 97 THE TREATING PROVIDER IS NOT A MEMBER OF THE GROUP THAT IS BILLING. NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT. 97 THE TREATING PROVIDER IS NOT A MEMBER OF THE GROUP THAT IS BILLING. NS5 ROCEDURES FOR BILLING WITH GROUP/REFERRING/PERFORMING PROVIDERS. WEER NOT FOLLOWED. WITHIN THREE YEARS OF PREVIOUS NEW PATIENT VISIT BY SAME PROVIDER. AN ESTABLISHED PATIENT VISIT MUST BE BILLED. HOME HEALIT SERVICE IS NOT INTERMITTENT AND DOES NOT MEET THE NUMBER OF DAYS OR UNITIS OF SERVICE EXCEEDS OUR ACCEPTABLE

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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
	POA INDICATOR OF N AND/OR U.				CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED
383	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	(MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT
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	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
	DIAGNOSTIC CASTS ARE PAYABLE ONLY WHEN THE CLAIM SPECIFIES THAT THEY ARE FOR ORTHODONTIA OR THAT THEY WERE REQUESTED BY				COVERAGE/PROGRAM GUIDELINES
427	THE CONSULTANT. THE MAXIMUM NUMBER OF SERVICE		THE NUMBER OF DAYS OR UNITS OF	272	WERE NOT MET BENEFIT MAXIMUM FOR THIS TIME
428	UNITS HAS BEEN EXCEEDED FOR A THREE- MONTH TIME PERIOD.	N362	SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119	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	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

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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
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	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	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	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	INDICATES THAT AN ATTACHMENT WAS SUBMITTED; HOWEVER, NO RELATED ATTACHMENT COULD BE IDENTIFIED.			163	ATTACHMENT/OTHER DOCUMENTATION REFERENCED ON THE CLAIM WAS NOT RECEIVED

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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
441	PROVIDER NOT ENROLLED FOR WAIVER TYPE BILLED. DME RENTAL FOR THIS ITEM HAS PREVIOUSLY BEEN PAID. ONLY ONE	N95	THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE.	8	INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT PREVIOUSLY PAID. PATMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS
442	RENTAL IS PAYABLE PER MONTH. THIS EXCEPTION TO POLICY SERVICE IS PAYABLE WITH SPECIFIC TIME LIMITS. THE SERVICE HAS PREVIOUSLY BEEN PAID WITHIN THE TIME LIMIT ALLOWED.			B13	PAYMENT 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. A CIRCUMCISION HAS PREVIOUSLY BEEN BILLED FOR THIS RECIPIENT. ONLY ONE CIRCUMCISION IS PAYABLE.	N706	MISSING DOCUMENTATION.	252 B13	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) PREVIOUSLY PAID. PAYMENT POR 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

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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
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.		i	4	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	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	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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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
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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 CHARGES FOR OUTPATIENT
475	AN OUTPATIENT CLAIM CANNOT BE BILLED WITHIN 72 HOURS OF AN INPATIENT STAY. ALL CHARGES MUST BE INCLUDED ON INPATIENT CLAIM. FIGURE TO THE PROPERTY OF THE PROP			60	SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN A PERIOD OF TIME PRIOR TO OR AFTER INPATIENT SERVICES
476 477	BEEN BILLED. PROPHYS AND/OR PROPHYS WITH FLUORIDE ARE PAYABLE EVERY 6 MONTHS (3 MONTHS IF MEDICAL NEED IS SHOWN) THE LIMIT ON X-RAYS LISTED IN THE MEDICAID PROVIDER MANUAL HAS BEEN EXCEEDED.	N362 N362	THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM.	119 119	BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED
480	IS BEING SUBMITTED FOR MEDICALLY NEEDY SPENDDOWN CONSIDERATION. CASE MANAGEMENT SERVICES FOR CHRONICALLY MENTALLY ILL (CMI) ARE PAYABLE BY MERIT.			178 24	PATIENT HAS NOT MET THE REQUIRED SPEND DOWN REQUIREMENTS 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. THE RECEPTION IS ENROLLED IN THE			24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN
484	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	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

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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
					CLAIM/SERVICE LACKS INFORMATION
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	OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT
					CLAIM/SERVICE LACKS INFORMATION
490	THE SEVENTH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS 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
	APPROVED CASE PLAN FOR THIS				
500	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	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	IS INCONSISTENT WITH THE PLACE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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382	MULTIPLE PROCEDURE PAYMENT REDUCTION APPLIED POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-	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 CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
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
					NON-COVERED CHARGE(S). AT LEAST
505	THE SURGERY BILLED IS A NON- PAYABLE COSMETIC SURGERY.	N383	NOT COVERED WHEN DEEMED COSMETIC.	96	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
303	TATABLE COSTILLIE SCHGLIKT.	11303	COSTILITE.		CLAIM/SERVICE LACKS INFORMATION
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	OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT
	THE SURGICAL PROCEDURE CODE				
507	(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
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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
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

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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
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	CODE OF 362 AND A TRANSPLANT ICD-9-CM SURGICAL PROCEDURE CODE IS NOT ON THE CLAIM. POSSIBLE INTERIM CLAIM. INTERIM			199	REVENUE CODE AND PROCEDURE CODE DO NOT MATCH
516	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
	USE VACCINE SUPPLY PROVIDED BY				AVAILABLE, AND SHOULD HAVE BEEN UTILIZED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT
518	THE CLAIM INDICATES AN ACCIDENT; THE DIAGNOSIS DOES NOT INDICATE AN ACCIDENT.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	B8	INFORMATION REF), IF PRESENT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT

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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
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
	RAY IS PAYABLE ONCE EVERY 5 YEARS UNLESS DOCUMENTATION OF NECESSITY IS PROVIDED ON THE				COVERAGE/PROGRAM GUIDELINES
525	THE ADMISSION HOUR IS EITHER MISSING OR INVALID. VALUES		MISSING/INCOMPLETE/INVALID	272	WERE NOT MET CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
530	ARE 00-23 AND 99. THE 9TH DIAGNOSIS CODE REQUIRES	N46	ADMISSION HOUR.	16	REMITT 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
532	MEDICAL REVIEW . A RELEVANT DIAGNOSIS IS REQUIRED TO ESTABLISH THE	N706	MISSING DOCUMENTATION.	252	AN ALERT) BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP
533	MEDICAL NECESSITY FOR THIS SERVICE. SKILLED NURSING CARE WITH A MENTAL HEALTH DIAGNOSIS MUST	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	50	2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED
535	BE BILLED TO IOWA PLAN.			24	CARE PLAN

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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
541	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 CHARGES ARE COVERED UNDER A
544	MENTAL HEALTH SERVICES MUST BE BILLED TO MBC OF IOWA			24	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	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 EXACT DOPLICATE CLAIM/SERVICE
557	DUPLICATE J-CODE			18	(USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REOUIRES 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	THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 LAST MODIFIED: 01/29/2012

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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	CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT
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	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	INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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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
564	THE SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS AGE.			6	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	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	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	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

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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
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

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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
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	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	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	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	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)

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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
			1		- , -
578	THE FIFTH SURGICAL PROCEDURE CODE REQUIRED MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	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	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	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	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	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)

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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
202	POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON- COVERED CHARGES AND/OR NON-		MISSING/INCOMPLETE/INVALID NON-COVERED DAYS DURING THE BILLING		CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
583	THE FOURTH SURGICAL PROCEDURE CODE REQUIRES MEDICAL REVIEW.	N706	MISSING DOCUMENTATION.	252	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	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	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	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.

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					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
302	REDUCTION ATTELED			39	,,
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
					ONE REMARK CODE MUST BE
					PROVIDED (MAY BE COMPRISED OF
					EITHER THE NCPDP REJECT REASON
			STATE REGULATED PATIENT		CODE, OR REMITTANCE ADVICE
	INVALID SURGICAL PROCEDURE		PAYMENT LIMITATIONS APPLY TO		REMARK CODE THAT IS NOT AN
588	CODE FOR FAMILY PLANNING.	N246	THIS SERVICE.	A1	ALERT.
	THE SYSTEM COULD NOT DETERMINE				
1	THE PROVIDER ID. IME DEFAULT				NATIONAL PROVIDER IDENTIFIER -
589	USED			208	NOT MATCHED
	BILLING NPI ON CLAIM CONFLICTS				NATIONAL PROVIDER IDENTIFIER -
590	WITH NPI ON FILE			208	NOT MATCHED
	PAY TO NPI ON CLAIM CONFLICTS				NATIONAL PROVIDER IDENTIFIER -
591	WITH NPI ON FILE			208	NOT MATCHED
	RENDERING NPI ON CLAIM			200	NATIONAL PROVIDER IDENTIFIER -
592	CONFLICTS WITH NPI ON FILE RENDERING AND PAY TO			208	NOT MATCHED
	PROVIDER/NPI DON'T HAVE THE				NATIONAL PROVIDER IDENTIFIER -
600	SAME TAX ID NUMBER			208	NOT MATCHED
- 500	SAME TAX TO NOMBER			200	
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	CEDVACEC DALLED CALCULATION CONTRACTOR		CLAIM INFORMATION TO		REMARK CODE MUST BE PROVIDED
	SERVICES BILLED ON CLAIM DO NOT		CLAIM INFORMATION IS		(MAY BE COMPRISED OF EITHER THE
	MATCH SERVICES APPROVED ON		INCONSISTENT WITH PRE-	4.5	NCPDP REJECT REASON CODE, OR
604	PRIOR AUTHORIZATION.	N54	CERTIFIED/AUTHORIZED SERVICES.	16	REMITT
					NON-COVERED CHARGE(S). AT LEAST
					ONE REMARK CODE MUST BE
					PROVIDED (MAY BE COMPRISED OF
					EITHER THE NCPDP REJECT REASON
	CLAIM SUBMITTED DOES NOT MATCH				CODE, OR REMITTANCE ADVICE
	LEVEL OF CARE APPROVAL FROM				REMARK CODE THAT IS NOT AN
	IFMC. IF CARE IS NON-ACUTE,		THE APPROVED LEVEL OF CARE DOES		ALERT.) USAGE: REFER TO THE 835
	CORRECT COND CODE & BILL TYPE		NOT MATCH THE PROCEDURE CODE		HEALTHCARE POLICY
609	MUST BE USED.	N188	SUBMITTED.	96	IDENTIFICATION SEGMENT (LOOP 2
500	IFMC. IF CARE IS NON-ACUTE, CORRECT COND CODE & BILL TYPE	NAOO	NOT MATCH THE PROCEDURE CODE	0.5	ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY
003	MOST DE OSED.	14100	JODE IT TED.		IDENTIFICATION SEGMENT (LOOF Z

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					PROCESSED BASED ON MULTIPLE OR
					CONCURRENT PROCEDURE RULES.
					(FOR EXAMPLE MULTIPLE SURGERY
					OR DIAGNOSTIC IMAGING,
					CONCURRENT ANESTHESIA.) USAGE:
					REFER TO THE 835 HEALTHCARE
	MULTIPLE PROCEDURE DAYMENT				POLICY IDENTIFICATION SEGMENT
202	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.		MATERIALO (TALGOLADI ETE (TAULAL ED ALGAL		REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
202	COVERED CHARGES AND/OR NON-	MA 22	COVERED DAYS DURING THE BILLING	1.0	NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
1					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
	UNITS BILLED ON CLAIM EXCEED THE				DOCUMENTATION. AT LEAST ONE
	UNITS APPROVED ON THE PRIOR		CI 4114 TNIFODMATTON TO		REMARK CODE MUST BE PROVIDED
	AUTHORIZA- TION. CLAIM OR PRIOR		CLAIM INFORMATION IS		(MAY BE COMPRISED OF EITHER THE
643	AUTHORIZATION MUST BE	NEA	INCONSISTENT WITH PRE-	4.0	NCPDP REJECT REASON CODE, OR
613	CORRECTED.	N54	CERTIFIED/AUTHORIZED SERVICES.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
	ANESTHESIA TIME UNITS MUST BE				DOCUMENTATION. AT LEAST ONE
	SUBMITTED - 1 UNIT PER MINUTE -				REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE
	IN THE UNITS FIELD ON THE CLAIM		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
618	FORM.	N203	ANESTHESIA TIME/UNITS.	16	REMITT
010	FORM.	11203	ANESTRESIA TIME/ONITS.	10	
					CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING
					-
					ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
	MISSING OR INVALID DIAGNOSIS				(MAY BE COMPRISED OF EITHER THE
	INDICATOR. VALID DIAGNOSIS		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
621	INDICATOR: VALID DIAGNOSIS INDICATORS ARE 1 - 4.	M76	DIAGNOSIS OR CONDITION.	16	REMITT
	INDIGHTONO / INC. I	, 0	SINGIO ON CONDITION	10	, .
					DOCUMENTATION IS REQUIRED TO
					ADJUDICATE THIS CLAIM/SERVICE.
					AT LEAST ONE REMARK CODE MUST
					BE PROVIDED (MAY BE COMPRISED
	THE DATE THE HOME HEALTH SHOW				OF EITHER THE NCPDP REJECT
	THE DATE THE HOME HEALTH PLAN		MICCINIC /INICOMPLETE /TAN /ALTO DI ANI		REASON CODE, OR REMITTANCE
624	WAS ESTABLISHED IS MISSING OR	M12F	MISSING/INCOMPLETE/INVALID PLAN)F)	ADVICE REMARK CODE THAT IS NOT
624	INVALID.	M135	OF TREATMENT.	252	AN ALERT)

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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
626	NON-COVERED CHARGES GREATER	M70	MISSING/INCOMPLETE/INVALID	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
626	THAN SUBMITTED CHARGE A VALID TOOTH SURFACE CODE IS	M79	CHARGE. MISSING/INCOMPLETE/INVALID	10	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
631	MISSING. THE TOOTH NUMBER IS INVALID OR NOT VALID FOR THE PROCEDURE	N75	TOOTH SURFACE INFORMATION. MISSING/INCOMPLETE/INVALID	16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
632	CODE. INVALID TOOTH SURFACE OR QUADRANT.	N37	TOOTH NUMBER/LETTER. MISSING/INCOMPLETE/INVALID TOOTH SURFACE INFORMATION.	16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT

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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
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	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	(ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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			1		
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
644	THE 10TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	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	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	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	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
653	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. CONSULT PLAN BENEFIT	29	THE TIME LIMIT FOR FILING HAS EXPIRED
655	PROVIDER TYPE MUST BE A PHYSICAN, AMBULANCE, OR NURSE PRACTITIONER. SERVICE NOT COVERED BY JOWA	N130	DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. CUNSULI PLAN BENEFIT	242	SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS
657	CARE. (OR) CLAIM IS NOT REFERRED BY BROADLAWNS PHYSICIANS OR HOSPITAL.	N130	DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.	204	THIS SERVICE/EQUIPMENT/DRUG IS NOT COVERED UNDER THE PATIENT'S CURRENT BENEFIT PLA

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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
658	SERVICE NOT COVERED BY IOWACARE - 300% OB GROUP POLICY	N130	CONSULT PLAIN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. CUINSULT PLAIN BENEFIT	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	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	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	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

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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
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	(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	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	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	WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON- COVERED CHARGES AND/OR NON-		MISSING/INCOMPLETE/INVALID NON- COVERED DAYS DURING THE BILLING		(MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
677	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 11TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
	THE RECIPIENT'S AGE ON THE				WITH THE PATIENT'S AGE. USAGE:
	ADMISSION DATE IS NOT WITHIN				REFER TO THE 835 HEALTHCARE
	THE MINIMUM & MAXIMUM SPECIFIED FOR THE FIFTH				POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT
680	DIAGNOSIS CODE BILLED.			9	INFORMATION REF), IF PRESENT
					CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE
682	THE 12TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	16	NCPDP REJECT REASON CODE, OR REMITT
	THE 12TH DIAGNOSIS CODE IS NOT		PATIENT INELIGIBLE FOR THIS		(ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT
683	COVERED BY IOWA MEDICAID	N30	SERVICE.	167	INFORMATION REF), IF PRESENT
					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
684	THE 12TH DIAGNOSIS REQUIRES ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	ADVICE REMARK CODE THAT IS NOT AN ALERT)
UUT	ATTACHILLIA	11/00	PILODING DOCUPLINTATION.	232	AN ALLAI)

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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
202	POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON- COVERED CHARGES AND/OR NON-	MA22	MISSING/INCOMPLETE/INVALID NON- COVERED DAYS DURING THE BILLING	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL THE 12TH DIAGNOSIS REQUIRES	MA33	PERIOD.	16	REMITT 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
685	MEDICAL REVIEW THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 12TH DIAGNOSIS CODE	N706	MISSING DOCUMENTATION.	252 9	AN ALERT) 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	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	(ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
303	COVERED DATS: REFER TO IE	MASS	TEIGOD.	10	, -
					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
	THE 13TH DIAGNOSIS REQUIRES				ADVICE REMARK CODE THAT IS NOT
690	ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ALERT)
					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
	THE 13TH DIAGNOSIS REQUIRES				ADVICE REMARK CODE THAT IS NOT
691	MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	AN ALERT)
			1.1202.10 2.000.12.111112011		THE DIMONIO IS INCONSISTENT
					WITH THE PATIENT'S AGE. USAGE:
					REFER TO THE 835 HEALTHCARE
	THE RECIPIENT'S AGE IS NOT				POLICY IDENTIFICATION SEGMENT
	ALLOWED FOR THE 13TH DIAGNOSIS				(LOOP 2110 SERVICE PAYMENT
692	CODE			9	INFORMATION REF), IF PRESENT
					WITH THE PATIENT'S GENDER.
					USAGE: REFER TO THE 835
					HEALTHCARE POLICY
	THE RECIPIENT'S SEX IS NOT				IDENTIFICATION SEGMENT (LOOP
	ALLOWED FOR THE 13TH DIAGNOSIS		RESUBMIT A NEW CLAIM WITH THE		2110 SERVICE PAYMENT
693	CODE	N517	REQUESTED INFORMATION.	10	INFORMATION REF), IF PRESENT
093	CODE	MOT/	REQUESTED INFORMATION.	10	
					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
	ATTENDING PROVIDER NOT				REMARK CODE THAT IS NOT AN
	ENROLLED WITH IOWA MEDICAID AS				ALERT.) USAGE: REFER TO THE 835
	REQUIRED BY THE AFFORDABLE CARE		REFERRAL NOT AUTHORIZED BY		HEALTHCARE POLICY
696	ACT	N630	ATTENDING PHYSICIAN.	96	IDENTIFICATION SEGMENT (LOOP 2
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					T
					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	NUMBER OF TOTAL UNITS BILLED				REMARK CODE MUST BE PROVIDED
	FOR ADMINISTRATION CODE (90460)				(MAY BE COMPRISED OF EITHER THE
	SHOULD NOT BE MORE THAN		PROCEDURE CODE IS INCONSISTENT		NCPDP REJECT REASON CODE, OR
697	VACCINES BILLED.	N430	WITH THE UNITS BILLED.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
	THE DISCHARGE HOUR IS MISSING				(MAY BE COMPRISED OF EITHER THE
	OR INVALID. VALID VALUES ARE 00-		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
698	23, AND 99.	N50	DISCHARGE INFORMATION.	16	REMITT
					SERVICES ARE NOT COVERED WHEN
	INPATIENT AND OUTPATIENT CLAIM				PERFORMED WITHIN A PERIOD OF
	WITHIN 72 HRS OF EACH OTHER				TIME PRIOR TO OR AFTER INPATIENT
699	CANNOT BE BILLED SEPARATELY.			60	SERVICES
099	CAINING DE DILLED SEFARATELT.			00	
					CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
					(MAY BE COMPRISED OF EITHER THE
	POS EDIT - MISSING UNIT DOSE				NCPDP REJECT REASON CODE, OR
1					
700	INDICATOR			16	REMITT

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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
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
	MISSING OR INVALID VERSION NUMBER. CONTACT YOUR				CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
702	MISSING OR INVALID TRANSACTION CODE. CONTACT YOUR SOFTWARE			16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
703	VENDOR. MISSING OR INVALID PROCESSOR CONTROL NUMBER. CONTACT YOUR SOFTWARE VENDOR.			16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT

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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
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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

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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
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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

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

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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 CLAIM/SERVICE LACKS INFORMATION
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	OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS 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

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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
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
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

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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
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
	MISSING OR INVALID PRIOR				CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
730	THE CLAIM REQUIRES DOCUMENTATION OF MEDICAL NECESSITY WHICH WAS NOT PROVIDED.			16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS 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

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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
724	MISSING OR INVALID PRESCRIPTION			16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
734	DENIAL OVERRIDE. MISSING OR INVALID PRIMARY			16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
735	PRESCRIBER.			16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
736	MISSING OR INVALID CLINIC ID.			16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
738	MISSING OR INVALID BASIS OF COST.			16	REMITT

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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
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	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

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3	882	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
3	883	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
7	'53	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
	'55	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

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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
750	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
759	NON-MATCHED CLINIC ID DRUG NOT COVERED FOR RECIPIENT			16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
760	AGE. DRUG NOT COVERED FOR RECIPIENT			16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
761	GENDER. PATIENT/CARD HOLDER ID NAME MISMATCH.			16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT

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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
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

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	MULTIPLE PROCEDURE PAYMENT				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
382	REDUCTION APPLIED			59	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
					CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
768	FILLED AFTER COVERAGE EXPIRED.			16	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
//1				10	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE
772	PRIMARY PRESCRIBER IS NOT COVERED.			16	NCPDP REJECT REASON CODE, OR REMITT

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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
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

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					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
					(MAY BE COMPRISED OF EITHER THE
					NCPDP REJECT REASON CODE, OR
780	DRUG-DIAGNOSIS MISMATCH.			16	REMITT
—	DATED FILLED IS AFTER DATE CLAIM			10	NEPH III.
	WAS RECEIVED. DATE OF SERVICE				
	SHOULD BE REVIEWED FOR				BILLING DATE PREDATES SERVICE
782	ACCURACY.			110	DATE
	INDATIONE DEADMICCION MUTUINI Z				
	INPATIENT READMISSION WITHIN 7				THIS CLAIM HAS BEEN IDENTIFIED
	DAYS FOR SAME CONDITION PRIOR				THIS CLAIM HAS BEEN IDENTIFIED
702	TO 7/1/15 OR WITHIN 30 DAYS FOR			240	AS A READMISSION. (USE ONLY WITH GROUP CODE CO
783	THE SAME CONDITION AFTER 7/1/15.			249	0.100. 0000
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
1					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
1					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
1	REVERSAL NOT PROCESSED. COULD				(MAY BE COMPRISED OF EITHER THE
1	NOT FIND ORIGINAL CLAIM BASED		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
784	ON THE CRITERIA SUBMITTED.	N152	REPLACEMENT CLAIM INFORMATION.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
1					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
1					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
1					(MAY BE COMPRISED OF EITHER THE
1					NCPDP REJECT REASON CODE, OR
786	SUBMIT MANUAL RESERVE.			16	REMITT

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				I	
					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
			-		CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
	DUD DEJECT FOR LITCH DOCACE OR				(MAY BE COMPRISED OF EITHER THE
700	DUR REJECT FOR HIGH DOSAGE OR			1.0	NCPDP REJECT REASON CODE, OR
788	THERAPEUTIC DUPLICATION.			16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
					(MAY BE COMPRISED OF EITHER THE
					NCPDP REJECT REASON CODE, OR
790	HOST SYSTEM UNAVAILABLE.			16	REMITT
1					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
1					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
	THIS CLAIM CANNOT BE PROCESSED				DOCUMENTATION. AT LEAST ONE
1	ONLINE THROUGH THE POINT OF				REMARK CODE MUST BE PROVIDED
1	SALE (POS) SYSTEM - SUFFICIENT				(MAY BE COMPRISED OF EITHER THE
	DOCUMENTATION WAS NOT				NCPDP REJECT REASON CODE, OR
799	PROVIDED FOR ADJUDICATION.			16	REMITT
					CERTIFIED/ELIGIBLE TO BE PAID FOR
					THIS PROCEDURE/SERVICE ON THIS
					DATE OF SERVICE. USAGE: REFER TO
	PROVIDER IS NOT AN ELIGIBLE				THE 835 HEALTHCARE POLICY
	PROVIDER IS NOT AN ELIGIBLE PROVIDER FOR THE DATE OF				IDENTIFICATION SEGMENT (LOOP
1	SERVICE BILLED ON THE CLAIM		MISSING/INCOMPLETE/INVALID		2110 SERVICE PAYMENT
800	FORM.	N570	CREDENTIALING DATA.	В7	INFORMATION REF), IF PRESENT
000	i UKIII.	143/0	CREDENTIALING DATA.	/ن	IN ORMATION REF), IF PRESENT

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		1			
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
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	INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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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
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	(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	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	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	WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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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
811	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 14TH DIAGNOSIS CODE	N517	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION.	10	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
814	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

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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
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

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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
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

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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
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	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	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

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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
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
042	APC GROUPER ERROR 005 - E- DIAGNOSIS CODE CAN NOT BE USED	MAC	MISSING/INCOMPLETE/INVALID	10	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
843	AS PRINCIPAL DIAGNOSIS APC GROUPER ERROR 006 - INVALID	MA63	PRINCIPAL DIAGNOSIS. MISSING/INCOMPLETE/INVALID	16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
844	APC GROUPER ERROR 017 - INAPPROPRIATE SPECIFICATION OF BILATERAL PROCEDURE	M51	PROCEDURE CODE(S). MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	16	REMITT CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT

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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
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	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

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	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
MULTIPLE PROCEDURE PAYMENT	(LOOP 2110 SERVICE PAYMENT
382 REDUCTION APPLIED 59	INFORMATION REF), IF PR
	CLAIM/SERVICE LACKS INFORMATION
	OR HAS SUBMISSION/BILLING
	ERROR(S). USAGE: DO NOT USE THIS
	` '
	CODE FOR CLAIMS
	ATTACHMENT(S)/OTHER
	DOCUMENTATION. AT LEAST ONE
POA INDICATOR OF N AND/OR U.	REMARK CODE MUST BE PROVIDED
CLAIM HAS OUTLIER AND NO NON- MISSING/INCOMPLETE/INVALID NON-	(MAY BE COMPRISED OF EITHER THE
COVERED CHARGES AND/OR NON- COVERED DAYS DURING THE BILLING	NCPDP REJECT REASON CODE, OR
383 COVERED DAYS. REFER TO IL MA33 PERIOD. 16	REMITT
	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
050 00000000000000000000000000000000000	COMPENSATION STATE
850 CORRECT CODING EDIT - CCI RULE 236	REGULATIONS/ FEE SCH
	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
851 CORRECT CODING EDIT - E/M 236	REGULATIONS/ FEE SCH
	INCLUDED IN THE
	PAYMENT/ALLOWANCE FOR ANOTHER
	SERVICE/PROCEDURE THAT HAS
	ALREADY BEEN ADJUDICATED.
	USAGE: REFER TO THE 835
THESE SERVICES ARE NOT COVERED	HEALTHCARE POLICY
WHEN PERFORMED WITHIN THE	IDENTIFICATION SEGMENT (LOOP
CORRECT CODING EDIT - GLOBAL GLOBAL PERIOD OF ANOTHER	2110 SERVICE PAYMENT
852 SURGERY N525 SERVICE. 97	INFORMATION REF), IF PRESENT
OSE SONGERT 11323 SERVICE. 37	-
	INCLUDED IN THE
	PAYMENT/ALLOWANCE FOR ANOTHER
	SERVICE/PROCEDURE THAT HAS
	ALREADY BEEN ADJUDICATED.
	USAGE: REFER TO THE 835
	HEALTHCARE POLICY
	HEALTHOAKE FOLICE
	IDENTIFICATION SEGMENT (LOOP
CORRECT CODING EDIT	IDENTIFICATION SEGMENT (LOOP
CORRECT CODING EDIT - PROCEDURE CODE INCIDENTAL TO 853 INCIDENTALS N19 PRIMARY PROCEDURE. 97	IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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					T
					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
382	MULTIPLE PROCEDURE PAYMENT REDUCTION APPLIED			59	(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
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
034	CORRECT CODING EDIT - MULTIPLE	NIIS	ACCESS,	90	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
855	SURGEONS			236	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	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

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					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
	MULTIPLE PROCEDURE DAVMENT				(LOOP 2110 SERVICE PAYMENT
	MULTIPLE PROCEDURE PAYMENT				1
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
			· ·		1 3
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
					INCLUDED IN THE
1					PAYMENT/ALLOWANCE FOR ANOTHER
					,
					SERVICE/PROCEDURE THAT HAS
					ALREADY BEEN ADJUDICATED.
					USAGE: REFER TO THE 835
			THESE SERVICES ARE NOT COVERED		HEALTHCARE POLICY
			WHEN PERFORMED WITHIN THE		IDENTIFICATION SEGMENT (LOOP
					`
l			GLOBAL PERIOD OF ANOTHER		2110 SERVICE PAYMENT
858	CORRECT CODING EDIT - OB	N525	SERVICE.	97	INFORMATION REF), IF PRESENT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					· ·
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
			MISSING/INCOMPLETE/INVALID		DOCUMENTATION. AT LEAST ONE
			DESCRIPTION OF SERVICE FOR A		REMARK CODE MUST BE PROVIDED
			NOT OTHERWISE CLASSIFIED (NOC)		(MAY BE COMPRISED OF EITHER THE
					\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
			CODE OR FOR AN UNLISTED/BY		NCPDP REJECT REASON CODE, OR
859	CORRECT CODING EDIT - UNLISTED	N350	REPORT PROCEDURE.	16	REMITT
					LAACT DUPLICATE CLAIM/SERVICE
					(USE ONLY WITH GROUP CODE OA
1			DUPLICATE OF A CLAIM PROCESSED,		EXCEPT WHERE STATE WORKERS'
			OR TO BE PROCESSED, AS A		COMPENSATION REGULATIONS
860	CORRECT CODING EDIT - DUPLICATE	N522	CROSSOVER CLAIM.	18	REQUIRES CO
F	THE 15TH DIAGNOSIS CODE IS NOT		MISSING/INCOMPLETE/INVALID		DIAGNOSIS WAS INVALID FOR THE
861	ON THE DIAGNOSIS FILE	M76	DIAGNOSIS OR CONDITION.	146	
901	ON THE DIAGNOSIS FILE	11/0	DIAGNOSIS OR CONDITION.	140	DATE(S) OF SERVICE REPORTED
1					(ARE) NOT COVERED. USAGE: REFER
1					TO THE 835 HEALTHCARE POLICY
1					IDENTIFICATION SEGMENT (LOOP
	THE 15TH DIAGNOSIS CODE IS NOT		PATIENT INELIGIBLE FOR THIS		2110 SERVICE PAYMENT
862	COVERED BY IOWA MEDICAID	N30	SERVICE.	167	INFORMATION REF), IF PRESENT
					. , .
					DOCUMENTATION IS REQUIRED TO
					ADJUDICATE THIS CLAIM/SERVICE.
1					AT LEAST ONE REMARK CODE MUST
					BE PROVIDED (MAY BE COMPRISED
					OF EITHER THE NCPDP REJECT
1					
					REASON CODE, OR REMITTANCE
1	THE 15TH DIAGNOSIS REQUIRES				ADVICE REMARK CODE THAT IS NOT
863	ATTACHMENTS	N706	MISSING DOCUMENTATION.	252	AN ALERT)
			1		

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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 CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER
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	DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT
864	THE 15TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	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	00		9	WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
866 867	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 15TH DIAGNOSIS CODE THE 16TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	N517 M76	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	10 146	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT 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	(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	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)

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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 CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS
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	ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT
870	THE 16TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	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	WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
872 873	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 16TH DIAGNOSIS CODE THE 17TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	N517 M76	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	10 146	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT 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	(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	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)

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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 CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS
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	ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT
876	THE 17TH DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	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	WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
878 879	THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 17TH DIAGNOSIS CODE THE DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE	N517 M76	RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.	10 146	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT 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	(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	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)

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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
					CLAIM/SERVICE LACKS INFORMATION
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	OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT
					DOCUMENTATION IS REQUIRED TO
882	THE DIAGNOSIS REQUIRES MEDICAL REVIEW	N706	MISSING DOCUMENTATION.	252	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)
					WITH THE PATIENT'S AGE. USAGE:
883	THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE DIAGNOSIS CODE			9	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	WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT
			THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE		BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT
885	CORRECT CODING EDIT - MUE	N362	MAXIMUM.	50	INFORMATION REF), IF PRESENT PATIENT HAS NOT MET THE
886	MEMBER IS NOT ELIGIBLE/ATTESTED FOR DATE OF SERVICE.			177	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

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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
888	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	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. DRG GROUPER WAS NOT ABLE TO	M15	SEPARATELY BILLED SERVICES/TESTS HAVE BEEN BUNDLED AS THEY ARE CONSIDERED COMPONENTS OF THE SAME PROCEDURE. SEPARATE PAYMENT IS NOT ALLOWED.	97	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	ASSIGN A DRG BASED ON THE DIAGNOSIS AND/ OR PROCEDURE CODING SUBMITTED.			A8	UNGROUPABLE DRG

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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
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

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	I				
					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
					(MAY BE COMPRISED OF EITHER THE
	A DRG BASE RATE IS NOT AVAILABLE		MISSING/INCOMPLETE/INVALID DRG		NCPDP REJECT REASON CODE, OR
899	FOR THE SERVICE BILLED.	N208	CODE.	16	REMITT
					LINE IS PENDING FURTHER REVIEW.
					(USE ONLY WITH GROUP CODE OA).
					USAGE: USE OF THIS CODE
					REQUIRES A REVERSAL AND
					CORRECTION WHEN THE SERVICE
	CLAIM IS IN PROCESS. PLEASE DO				LINE IS FINALIZED (USE ONLY IN
	NOT RESUBMIT THE CLAIM PRIOR TO		ALERT: DO NOT RESUBMIT THIS		LOOP 2110 CAS SEGMENT OF THE
900	PAYMENT OR DENIAL.	N185	CLAIM/SERVICE.	133	835 OR LOOP 2430 OF
	-		, , , , , ,		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
	THE MEMBER WAS NOT,AT				ALERT.) USAGE: REFER TO THE 835
	LEAST,AGE 21 WHEN COUNSELING		NOT ELIGIBLE DUE TO THE		HEALTHCARE POLICY
901	WAS PROVIDED.	N129	PATIENT'S AGE.	96	IDENTIFICATION SEGMENT (LOOP 2
—		/			, `
					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
	THE STERILIZATION CONSENT FORM				
	IS NOT LEGIBLE OR IS COMPLETED		INCOMPLETE/INVALID CONSENT		(MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
902	INCORRECTLY.	N228	FORM.	251	RE
302	INCORRECTET.	11/2/2/0	i Onii.	2 J1	IXL

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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
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 50-DAT WAITING PERIOD FOR STERILIZATION WAS NOT MET, 180 DAY MAXIMUM EXCEEDED OR 72 HR WAITING PERIOD FOR EMERGENCY STERILIZATION WAS NOT MET	1102		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	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	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	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

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	1		T	ı	1
					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
382	MULTIPLE PROCEDURE PAYMENT REDUCTION APPLIED			59	(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
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	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	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	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

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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
912	THE ABORTION CERTIFICATE WAS NOT ATTACHED/MUST BE THE REVISED 07/11 VERSION.	N398	MISSING ELECTIVE CONSENT FORM.	252	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	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	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	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	WITH THE PROCEDURE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	`INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	A DIAGNOSIS OR DOCUMENTATION				REMARK CODE MUST BE PROVIDED
	INDICATING THE OUTCOME OF THE				(MAY BE COMPRISED OF EITHER THE
	DELIVERY IS REQUIRED TO REVIEW		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
917	THE CLAIM.	M76	DIAGNOSIS OR CONDITION.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
			MISSING/INCOMPLETE/INVALID		DOCUMENTATION. AT LEAST ONE
	UNLISTED PROCEDURES CPT/HCPS		DESCRIPTION OF SERVICE FOR A		REMARK CODE MUST BE PROVIDED
	CODES MUST BE CLEARLY		NOT OTHERWISE CLASSIFIED (NOC)		(MAY BE COMPRISED OF EITHER THE
	IDENTIFIED IN BOX 19 ON CLAIM		CODE OR FOR AN UNLISTED/BY		NCPDP REJECT REASON CODE, OR
918	FORM.	N350	REPORT PROCEDURE.	16	REMITT
F	. 5.4.11				,
					DOCUMENTATION IS REQUIRED TO
					ADJUDICATE THIS CLAIM/SERVICE.
					AT LEAST ONE REMARK CODE MUST
	LIVETEDECTOMY				BE PROVIDED (MAY BE COMPRISED
	HYSTERECTOMY ACKNOWLEDGEMENT OR				OF EITHER THE NCPDP REJECT
	STERILIZATION CONSENT IS				REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT
919	MISSING.	N3	MISSING CONSENT FORM.	252	AN ALERT)
919	PILOSING.	CFI	INISSING CONSENT FORM.	۷۵۷	,
					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
	TUE CED (100 000)				ALERT.) USAGE: REFER TO THE 835
	THE SERVICE/PROCEDURE BILLED IS	N/405	CTATUTODAY FVCI LIDED CED (TOT (C)	66	HEALTHCARE POLICY
920	NOT A MEDICAID BENEFIT.	N425	STATUTORILY EXCLUDED SERVICE(S).	96	IDENTIFICATION SEGMENT (LOOP 2

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	T		T		T
	MULTIPLE PROCEDURE PAYMENT			5 2	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
382	REDUCTION APPLIED			59	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
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	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	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	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

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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
926	THE DOCUMENTATION SUBMITTED IS NOT LEGIBLE.	N205	INFORMATION PROVIDED WAS ILLEGIBLE.	251	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	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	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

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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
930	SUPPORTING ULTRASOUND DOCUMENTATION IS REQUIRED IN ORDER TO EVALUATE THIS CLAIM.	M60	MISSING CERTIFICATE OF MEDICAL NECESSITY.	252	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	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	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

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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
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	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	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

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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
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	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. PRIOR AUTHORIZATION FOR THE	M86	SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME.	97	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 SERVICES DENIED AT THE TIME
943	THE MEDICAL NEED FOR THE AMBULANCE WAS NOT PROVIDED.	M62 N115	MISSING/INCOMPLETE/INVALID TREATMENT AUTHORIZATION CODE. 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,	39 50	AUTHORIZATION/PRE- CERTIFICATION WAS REQUESTED 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

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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
946	AIR AMBULANCE NEED WAS NOT SHOWN.	N115	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	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

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					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
382	MULTIPLE PROCEDURE PAYMENT REDUCTION APPLIED			59	(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
950	USE OF THE 22 MODIFIER IS NOT WARRANTED BASED ON REVIEW OF THE DOCUMENTATION PROVIDED.	N519	INVALID COMBINATION OF HCPCS MODIFIERS.	4	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	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	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

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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
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	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	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	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	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)

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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
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	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	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)

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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
963	PROGRESS NOTES ARE MISSING.	N393	MISSING PROGRESS NOTES/REPORT.	252	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	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

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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
967	THE PLACE OF SERVICE FIELD MUST REFLECT THE LOCATION WHERE SERVICE WAS PROVIDED.	M77	MISSING/INCOMPLETE/INVALID/INAP PROPRIATE 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	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	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

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					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
302	REDUCTION AFFEILD			39	
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
1					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
					(MAY BE COMPRISED OF EITHER THE
	AN INCORDECT CONDITION CODE		MICCINIC/INICOMDLETE/INIVALID		
971	AN INCORRECT CONDITION CODE WAS USED.	M44	MISSING/INCOMPLETE/INVALID CONDITION CODE.	16	NCPDP REJECT REASON CODE, OR REMITT
9/1	WAS USED.	14144	CONDITION CODE.	10	
					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
	INCOMPLETE/INVALID				(MAY BE COMPRISED OF EITHER THE
	DOCUMENTATION/ORDERS/NOTES/S		INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
972	UMMARY/REPORT/CHART.	N705	DOCUMENTATION.	251	RE
					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
			PAYMENT FOR REPAIR OR		REMARK CODE THAT IS NOT AN
			REPLACEMENT IS NOT COVERED OR		ALERT.) USAGE: REFER TO THE 835
	REPAIR OR REPLACEMENT OF DME IS		HAS EXCEEDED THE PURCHASE		HEALTHCARE POLICY
973	NOT COVERED.	N171	PRICE.	96	IDENTIFICATION SEGMENT (LOOP 2
9/3	NOT COVERED.	INT/T	FRICE.	30	, `
					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
974	THE PHYSICIAN ORDER IS MISSING.	N455	MISSING PHYSICIAN ORDER.	252	AN ALERT)
	1		1		

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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
975	SERVICE BILLED MUST BE CLEARLY IDENTIFIED ON INVOICE.	N354	INCOMPLETE/INVALID INVOICE.	251	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	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	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	INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT

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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
202	POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON- COVERED CHARGES AND/OR NON-	Man	MISSING/INCOMPLETE/INVALID NON-COVERED DAYS DURING THE BILLING	16	CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT NATIONAL DRUG CODES (NDC) NOT
980	THE NDC IS NOT A REBATABLE NDC.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).	211	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	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	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	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)

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	1				
					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
302	REDUCTION AFFEILD			39	
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
					REMARK CODE MUST BE PROVIDED
	DATE OF V DAV IC INVALID CHECK V				(MAY BE COMPRISED OF EITHER THE
	DATE OF X-RAY IS INVALID. CHECK X- RAY DATE FOR VALIDITY UNDER		MISSING/INCOMPLETE/INVALID LAST		1
005		Naac	MISSING/INCOMPLETE/INVALID LAST	16	NCPDP REJECT REASON CODE, OR
985	IOWA MEDICAID POLICY.	N326	X-RAY DATE.	16	REMITT
					DOCUMENTATION IS REQUIRED TO
					ADJUDICATE THIS CLAIM/SERVICE.
					AT LEAST ONE REMARK CODE MUST
					BE PROVIDED (MAY BE COMPRISED
					OF EITHER THE NCPDP REJECT
	DIAGNOSTIC TESTING OR				REASON CODE, OR REMITTANCE
	LABORATORY REPORTS ARE				ADVICE REMARK CODE THAT IS NOT
986	REQUIRED TO REVIEW THIS CLAIM.	N395	MISSING LABORATORY REPORT.	252	AN ALERT)
	,				DOCUMENTATION THAT WAS
					RECEIVED WAS INCOMPLETE OR
					DEFICIENT. THE NECESSARY
					INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE
	DOCUMENTATION MUST INCLUDE				
1	DOCUMENTATION MUST INCLUDE		MICCINIC /INICONADI ETE /INIVALITO		REMARK CODE MUST BE PROVIDED
	DOSE/STRENGTH OF MEDICATION		MISSING/INCOMPLETE/INVALID		(MAY BE COMPRISED OF EITHER THE
007	AND HEIGHT/WEIGHT AND BSA OF	M4 22	NAME, STRENGTH, OR DOSAGE OF	254	NCPDP REJECT REASON CODE, OR
987	MEMBER.	M123	THE DRUG FURNISHED.	251	RE
					DOCUMENTATION THAT WAS
					RECEIVED WAS INCOMPLETE OR
					DEFICIENT. THE NECESSARY
1					INFORMATION IS STILL NEEDED TO
	PHYSICIAN STATEMENT MUST BE				PROCESS THE CLAIM. AT LEAST ONE
	SIGNED BY THE PHYSICIAN WHO				REMARK CODE MUST BE PROVIDED
	PERFORMED THE PROCEDURE. A				(MAY BE COMPRISED OF EITHER THE
	STAFF SIGNATURE IS NOT		MISSING/INCOMPLETE/INVALID		NCPDP REJECT REASON CODE, OR
					·
988	ACCEPTABLE.	MA81	PROVIDER/SUPPLIER SIGNATURE.	251	RE

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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
989	REQUIRED ABORTION DOCUMENTATION IS MISSING.	N706	MISSING DOCUMENTATION.	252	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	(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	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	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

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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
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	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	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	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	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

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					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
	MULTIPLE PROCEDURE PAYMENT				(LOOP 2110 SERVICE PAYMENT
382	REDUCTION APPLIED			59	INFORMATION REF), IF PR
					CLAIM/SERVICE LACKS INFORMATION
					OR HAS SUBMISSION/BILLING
					ERROR(S). USAGE: DO NOT USE THIS
					CODE FOR CLAIMS
					ATTACHMENT(S)/OTHER
					DOCUMENTATION. AT LEAST ONE
	POA INDICATOR OF N AND/OR U.				REMARK CODE MUST BE PROVIDED
	CLAIM HAS OUTLIER AND NO NON-		MISSING/INCOMPLETE/INVALID NON-		(MAY BE COMPRISED OF EITHER THE
	COVERED CHARGES AND/OR NON-		COVERED DAYS DURING THE BILLING		NCPDP REJECT REASON CODE, OR
383	COVERED DAYS. REFER TO IL	MA33	PERIOD.	16	REMITT
					DOCUMENTATION IS REQUIRED TO
					ADJUDICATE THIS CLAIM/SERVICE.
					AT LEAST ONE REMARK CODE MUST
					BE PROVIDED (MAY BE COMPRISED
					OF EITHER THE NCPDP REJECT
	A PHYSICIAN ORDER SIGNED AND				REASON CODE, OR REMITTANCE
	DATED WITHIN THE LAST YEAR OF				ADVICE REMARK CODE THAT IS NOT
999	SERVICE REQUEST IS REQUIRED.	N455	MISSING PHYSICIAN ORDER.	252	AN ALERT)

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