# EOB Crosswalk

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

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

# EOB Crosswalk

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

# EOB Crosswalk

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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 023 | INVALID OR MISSING ADMISSION TYPE. PLEASE UPDATE CLAIM AND RESUBMIT. VALID VALUES ARE 1-5 FOR ADMISSION TYPE. | MA40 | MISSING/INCOMPLETE/INVALID ADMISSION DATE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 024 | THE PAYOR CODE IS NOT A VALID VALUE, OR ONE OF THE PAYOR CODES IS NOT EQUAL TO 1 INDICATING MEDICAID. | M56 | MISSING/INCOMPLETE/INVALID PAYER IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 025 | THE TYPE OF BILL IS NOT A VALID VALUE. REFER TO YOUR BILLING MANUAL TO FIND THE CORRECT TYPE OF BILL FOR THE CLAIM AND RESUBMIT. | MA30 | MISSING/INCOMPLETE/INVALID TYPE OF BILL. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 026 | LENGTH OF STAY EXCEEDED FOR DIAGNOSIS | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 027 | MULTIPLE/FRAGMENTED METHODS OF ADMINISTRATION HAVE BEEN BILLED. | N19 | PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 028 | THE MEDICAID MAXIMUM FOR CROWNS IS TWO PER 12 MONTH PERIOD. THIS MAXIMUM HAS BEEN EXCEEDED. | M90 | NOT COVERED MORE THAN ONCE IN A 12 MONTH PERIOD. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 029 | THE PATIENT STATUS IS INVALID. PLEASE REFER TO YOUR BILLING MANUAL FOR THE VALID VALUES. | MA43 | MISSING/INCOMPLETE/INVALID PATIENT STATUS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 030 | THE NUMBER OF DAYS BILLED IS NOT EQUAL TO THE ROOM AND BOARD UNITS. | M52 | MISSING/INCOMPLETE/INVALID "FROM" DATE(S) OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 031 | THE DATE OF SERVICE IS AFTER THE DATE THE CLAIM WAS RECEIVED. | | ... | 110 | BILLING DATE PREDATES SERVICE DATE |
| 032 | THE MAXIMUM AMOUNT OF CRITICAL CARE BILLABLE UNDER THIS CODE IS ONE HOUR PER DATE OF SERVICE. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 033 | THE PROCEDURE CODE IS NOT APPROVED FOR BILLING AMBULANCE SERVICES. | N56 | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 034 | THE MAXIMUM NUMBER OF SERVICES ALLOWABLE FOR THE PROCEDURE BILLED HAS BEEN EXCEEDED. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 035 | THE LINE ITEM REVENUE CODE IS MISSING. | M50 | MISSING/INCOMPLETE/INVALID REVENUE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 036 | THE SERVICE LIMIT FOR DENTAL EXAMS/X-RAYS HAS BEEN EXCEEDED. CHECK THE DATE OF THE LAST EXAM BASED ON PROVIDER MANUAL CRITERIA. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 037 | A MEDICARE PAID AMOUNT IS SHOWN ON THE CLAIM FORM. IF THIS IS CORRECT, A MEDICARE EOMB MUST BE SUBMITTED FOR DEDUCTIBLE/COINSURANCE PROCESSING. | N479 | MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER). | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 038 | THERE IS A MAXIMUM OF ONE DISPENSING FEE PER MONAURAL OR TWO FEES FOR BINAURAL AIDS WITHOUT PRIOR APPROVAL IN FOUR YEARS. THIS WAS EXCEEDED. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 039 | THE NDC (DRUG) CODE IS MISSING. ENTER THE CORRECT NDC CODE AND RESUBMIT THE CLAIM. | M119 | MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 040 | THE NUMBER OF SERVICES ALLOWED FOR THIS PROCEDURE CODE HAS BEEN EXCEEDED. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 041 | THE PRESCRIPTION NUMBER IS MISSING OR INVALID. CORRECT THE PRESCRIPTION NUMBER AND RESUBMIT THE CLAIM. | | ... | 175 | PRESCRIPTION IS INCOMPLETE |
| 042 | THE QUANTITY OF THE DISPENSED DRUG IS ZEROES. ENTER THE CORRECT DRUG QUANTITY AND RESUBMIT THE CLAIM. | N378 | MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 043 | THE RECIPIENT IS OLDER THAT THE MAXIMUM AGE ALLOWED TO RECEIVE THIS SERV ICE. | N129 | NOT ELIGIBLE DUE TO THE PATIENT'S AGE. | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 044 | THE TOTAL CLAIM CHARGE AMOUNT AND THE SUM OF THE LINE ITEM CHARGES ARE NOT EQUAL. | M54 | MISSING/INCOMPLETE/INVALID TOTAL CHARGES. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 045 | THE DIAGNOSIS OR THE LINE ITEM DIAGNOSIS IS MISSING. CORRECT THE DIAGNOSIS CODE ANDD RESUBMIT THE CLAIM. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 046 | ONLY ONE VISIT/TREATMENT/ENCOUNTER IS PAYABLE PER DATE OF SERVICE. ADDITIONAL SERVICES DO NOT MEET CONCURRENT CARE GUIDELINES. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | B14 | ONLY ONE VISIT OR CONSULTATION PER PHYSICIAN PER DAY IS COVERED |
| 047 | THE RECIPIENT'S AGE IS INVALID FOR THE DRG ASSIGNED BY THE DRG GROUPER. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 048 | THE CROSSOVER DEDUCTIBLE AMOUNT EXCEEDS THE ALLOWED DEDUCTIBLE LIMIT FOR THE YEAR THAT THE SERVICE WAS PERFORMED. | N23 | ALERT: PATIENT LIABILITY MAY BE AFFECTED DUE TO COORDINATION OF BENEFITS WITH OTHER CARRIERS AND/OR MAXIMUM BENEFIT PROVISIONS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 049 | THE ADMISSION DATE OR ACTION CODE IS MISSING OR INVALID. | MA40 | MISSING/INCOMPLETE/INVALID ADMISSION DATE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 050 | A URINALYSIS IS CONSIDERED PART OF ROUTINE PRENATAL CARE AND IS NOT PAYABLE SEPARATELY. | N19 | PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 051 | ONLY ONE CONSULTATION IS PAYABLE PER RECIPIENT/PER PROVIDER. SUBSEQUENT CONSULTATIONS MUST BE BILLED AS OFFICE/HOSPITAL VISITS. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 052 | THE SERVICE LIMIT FOR THIS EXCEPTION TO POLICY SERVICE HAS BEEN EXCEEDED. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 053 | THE NUMBER OF TREATMENTS EXCEEDS THE MAXIMUM NUMBER ALLOWED BY MEDICAID. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 054 | ANY ONE OF THE LINE ITEM PROCEDURE DATES IS AFTER THE DATE THE CLAIM WAS RECEIVED. | | ... | 110 | BILLING DATE PREDATES SERVICE DATE |

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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 055 | THE ADMISSION SOURCE IS MISSING OR INVALID. VALID VALUES ARE 1-9 AND D. | MA42 | MISSING/INCOMPLETE/INVALID ADMISSION SOURCE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 057 | REQUIRED NDC MISSING, INVALID OR NOT ON THE PREFERRED LIST. DIABETIC SUPPLY (MONITOR/STRIP/SYRINGE/LANCET) REQUIRES NDC | M119 | MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 058 | MULTIPLE ECHOGRAPHY CODES CANNOT BE BILLED ON THE SAME DATE IF A COMPLETE PROCEDURE IS ALSO BILLED. | N19 | PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 059 | AN EXAMINATION CANNOT BE BILLED ON THE SAME DAY AS AN EYE REFRACTION. A REFRACTION IS PAYABLE SEPARATELY ONLY WHEN MEDICARE PAYS THE EXAM. | N19 | PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 060 | THE DISCHARGE DATE OR TERMINATION CODE IS MISSING OR INVALID. | N318 | MISSING/INCOMPLETE/INVALID DISCHARGE OR END OF CARE DATE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 061 | FRAGMENTED OB SERVICES WERE BILLED. OB DELIVERY MUST BE BILLED AS A GLOBAL CHARGE - C-SECTION OR OBSTETRICAL DELIVERY. | M144 | PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |

# EOB Crosswalk

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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 062 | THE 1ST SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE. | N301 | MISSING/INCOMPLETE/INVALID PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 063 | THE 2ND SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 064 | THE 3RD SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 065 | THE 4TH SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 066 | THE 5TH SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 067 | THE SURGERY DATE IS NOT WITHIN THE FROM/THRU DATES OF SERVICE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 068 | INVALID DATES WERE BILLED AS "FROM/THROUGH" DATES OF SERVICE. | MA31 | MISSING/INCOMPLETE/INVALID BEGINNING AND ENDING DATES OF THE PERIOD BILLED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 069 | 1ST SURGICAL PROCEDURE CODE IS MISSING & THE REVENUE CODE INDICATES A SURGERY WAS PERFORMED. RESUBMIT THE CLAIM WITH CORRECT SURG. PROC. CODE. | MA66 | MISSING/INCOMPLETE/INVALID PRINCIPAL PROCEDURE CODE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 070 | THE 1ST SURGICAL PROCEDURE CODE DOES NOT HAVE A CORRESPONDING SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT 1ST SURGICAL PROCEDURE DATE. | N303 | MISSING/INCOMPLETE/INVALID PRINCIPAL PROCEDURE DATE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 071 | THE 2ND SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT SECOND SURGICAL PROCEDURE DATE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 072 | THE 3RD SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT THIRD SURGICAL PROCEDURE DATE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 073 | THE 4TH SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT FOURTH SURGICAL PROCEDURE DATE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 074 | 5TH DIAGNOSIS INCORRECT AS SUBMITTED. PLEAS CORRECT AND RESUBMIT CLAIM. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 075 | THE 5TH SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE. RESUBMIT THE CLAIM WITH THE CORRECT FIFTH SURGICAL PROCEDURE DATE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 076 | THE REFERRING PROVIDER NUMBER IS ZEROES. | N286 | MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 077 | THE SURGICAL PROCEDURE CODE DOES NOT HAVE A VALID SURGICAL DATE RESUBMIT THE CLAIM WITH THE CORRECT SURGICAL PROCEDURE DATE. | N302 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 078 | THE NUMBER OF DAYS BILLED DO NOT MATCH THE FIRST DATE OF SERVICE THROUGH THE LAST DATE OF SERVICE. | N345 | DATE RANGE NOT VALID WITH UNITS SUBMITTED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 079 | MAXIMUM LIMIT EXCEEDED. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 080 | THE BILLING PROVIDER NUMBER IS A TREATING PROVIDER. A SEPARATE GROUP NUMBER MUST BE SHOWN FOR THE PAY-TO PROVIDER IN THE CORRECT FIELD. | N55 | PROCEDURES FOR BILLING WITH GROUP/REFERRING/PERFORMING PROVIDERS WERE NOT FOLLOWED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 081 | THIS SERVICE IS CONSIDERED A MEDICARE-COVERED SERVICE. THE CLAIM DID NOT MEET MEDICAID PAYMENT CRITERIA FOR DIRECT MEDICAID BILLING. | N479 | MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 082 | ONLY ONE MEDICAL CASE MANAGEMENT IS ALLOWED PER CALENDAR MONTH. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 083 | THIS ITEM HAS BEEN PREVIOUSLY PURCHASED AND IS NOT ELIGIBLE FOR ANOTHER PURCHASE AT THIS TIME. IF THIS WAS RENTAL, MODIFIER RR IS REQUIRED. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 108 | RENT/PURCHASE GUIDELINES WERE NOT MET. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 084 | 12 EMERGENCY RESPONSE CLAIMS ARE PAYABLE PER 12 MONTH PERIOD (ONE PER MONTH). THIS NUMBER HAS BEEN EXCEEDED. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 085 | THE RECIPIENT ID NUMBER IS NOT ON FILE. THE CLAIM MUST BE RESUBMITTED WITH THE CORRECT RECIPIENT ID NUMBER. | | ... | 31 | PATIENT CANNOT BE IDENTIFIED AS OUR INSURED |
| 086 | FRAGMENTED X-RAY CHARGES WERE BILLED. BITEWINGS OR PANORAMIC X-RAY CANNOT BE BILLED IN ADDITION TO A FULL-MOUTH X-RAY. | N20 | SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 087 | THE SERVICE LIMIT FOR THIS CONDITION HAS BEEN EXCEEDED BASED ON DIAGNOSES SUBMITTED ON THE CLAIM. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 088 | THE 7TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 089 | THE SERVICE LIMIT FOR THE PROCEDURE BILLED HAS BEEN EXCEEDED OR THIS REPRESENTS FRAGMENTATION WITH OTHER SERVICES BILLED. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |

# EOB Crosswalk

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

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 097 | SERVICE NOT COVERED FOR RECIPIENT. THE STATE ELIGIBILITY FILE SHOWS LIMITED OR NO MEDICAID ELIGIBILITY FOR THE DATE OF SERVICE. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 098 | THE RECIPIENT IS IN THE LOCK-IN PROGRAM. THE BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES. | | ... | 242 | SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS |
| 099 | INVALID ICD-10 PRINCIPAL DIAGNOSIS CODE | MA63 | MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 100 | DIAGNOSIS BILLEDIS NOT A REASON FOR HOSPITAL SERVICE BASED ON APG/DRG GROUPER. DIAGNOSIS BILLED MUST BE 5 DIGIT CODE IF 5 DIGITS ARE AVAILABLE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 101 | THE REFERRING PROVIDER NUMBER IS NOT A VALID MEDICAID PROVIDER NUMBER OR HAS BEEN TERMED BY THE MEDICAID AUTHORITY FOR THE DATE OF SERVICE. | N286 | MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 102 | THE SUBMITTER IS NOT ALLOWED TO SUBMIT ELECTRONIC CLAIMS FOR THE BILLING PROVIDER. | N34 | INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 103 | CONCURRENT CARE WAS PROVIDED. THIS SERVICES REPRESENTS A DUPLICATION OR OVERLAP OF SERVICES PROVIDED BY THE SAME OR A DIFFERENT PROVIDER. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 104 | THE EIGHTH DIAGNOSIS CODE IS NOT COVERED BY MEDICAID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 105 | THE SPECIAL ABSTRACT TRANSACTION CONTAINED AN ERROR WHICH CAUSED THE CLAIM TO DENY. CONTACT PROVIDER RELATIONS. | | ... | 107 | THE RELATED OR QUALIFYING CLAIM/SERVICE WAS NOT IDENTIFIED ON THIS CLAIM. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 106 | INCORECT GROSS ADJUSTMENT AMOUNT FOR A DEBIT. PLEASE CORRECT AND RESUBMIT CLAIM. | M54 | MISSING/INCOMPLETE/INVALID TOTAL CHARGES. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 107 | INCORECT GROSS ADJUSTMENT AMOUNT FOR A CREDIT. PLEASE CORRECT AND RESUBMIT CLAIM. | M54 | MISSING/INCOMPLETE/INVALID TOTAL CHARGES. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 108 | THIS ITEM OR SERVICE CANNOT BE PAID FOR RESIDENTS OF A NURSING HOME. THE CHARGE MUST BE BILLED TO THE FACILITY. | N79 | SERVICE BILLED IS NOT COMPATIBLE WITH PATIENT LOCATION INFORMATION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 109 | REIMBURSEMENT HAS NOT BEEN AUTHORIZED FOR THE SERVICE BILLED. | | ... | 197 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT |
| 110 | MISSING OR INVALID LEVEL OF CARE. CORRECT AND RESUBMIT THE CLAIM. | N188 | THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 111 | IOWA MEDICAID DOES NOT PAY FOR A RELATED MEDICAL VISIT FALLING WITHIN THE SURGERY PRE-OP PERIOD. | M144 | PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 112 | PROVIDER ENROLLMENT RECORDS DO NOT SHOW THE PROVIDER AUTHORIZED TO BILL THIS SERVICE. | N570 | MISSING/INCOMPLETE/INVALID CREDENTIALING DATA. | B7 | THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 113 | THE PROCEDURE CODE BILLED IS NOT VALID FOR THIS WAIVER TYPE. . | N56 | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 114 | THE RECIPIENT'S AGE IS OUTSIDE THE RANGE ALLOWABLE FOR THE DIAGNOSIS BASED ON THE ICD-9-CM DESCRIPTION. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 115 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE DIAGNOSIS/PROCEDURE BILLED BASED ON THE CODE'S DESCRIPTION. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 116 | PROVIDER NUMBER BILLED DOES NOT INDICATE AN ANESTHESIOLOGIST. ONLY AN ANESTHESIOLOGIST CAN MEDICALLY DIRECT A CRNA - MODIFIER AB OR AC. | | ... | 8 | THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 117 | MEDICAL VISITS ARE NOT PAYABLE SEPARATELY WHEN BILLED DURING PRE & POST OP PERIOD. PRE & POST-OP VISITS ARE PART OF SURGICAL FEE. | M144 | PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 118 | THERE WAS TPL INDICATED ON THE CLAIM BUT NOT ON THE RECIPIENT'S FILE. | MA92 | MISSING PLAN INFORMATION FOR OTHER INSURANCE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 119 | THE TYPE OF BILL SHOWN ON THE UB 04 IS NOT A TYPE OF BILL APPROVED FOR THE PROVIDER BILLING THE SERVICE TO IOWA MEDICAID. | MA30 | MISSING/INCOMPLETE/INVALID TYPE OF BILL. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 120 | THE PROVIDER NUMBER SUBMITTED IS INCORRECT, PLEASE CORRECT AND RESUBMIT THE CLAIM. | N257 | MISSING/INCOMPLETE/INVALID BILLING PROVIDER/SUPPLIER PRIMARY IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 121 | THE BILLING PROVIDER NUMBER IS NOT ON THE PROVIDER MASTER FILE. | | ... | 208 | NATIONAL PROVIDER IDENTIFIER - NOT MATCHED |
| 122 | THIS IS AN EPSDT DIAGNOSIS CODE AND THE RECIPIENT IS 21 OR OLDER. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 123 | THE QUANTITY DISPENSED FOR THE NDC IS BELOW THE MINIMUM QUANTITY. | N378 | MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 124 | THE QUANTITY DISPENSED FOR THE NDC IS GREATER THAN THE MAXIMUM QUANTITY. | N378 | MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 125 | THE RECIPIENT IS YOUNGER THAN THE MINIMUM AGE ALLOWED TO RECEIVE THIS DRUG. | M123 | MISSING/INCOMPLETE/INVALID NAME, STRENGTH, OR DOSAGE OF THE DRUG FURNISHED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 126 | THE RECIPIENT IS OLDER THAN THE MAXIMUM AGE ALLOWED TO RECEIVE THIS DRUG. | M123 | MISSING/INCOMPLETE/INVALID NAME, STRENGTH, OR DOSAGE OF THE DRUG FURNISHED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 127 | THE DIAGNOSIS BILLED IS EITHER NON-PAYABLE OR REQUIRES ADDITIONAL DIAGNOSIS IN ORDER TO MEET MEDICAL NECESSITY CRITERIA. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 128 | THE DIAGNOSIS BILLED REQUIRES AN ATTACHMENT - THE STERILIZATION CONSENT FORM, THE ABORTION CERTIFICATION, THE HYSTERECTOMY STATEMENT, ETC. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 129 | THE DIAGNOSIS CODE BILLED IS NOT A VALID DIAGNOSIS CODE FOR IOWA MEDICAID. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 130 | DIAGNOSIS CODE IS NOT COVERED AS BILLED. IF APPLICABLE, CLAIM CAN BE RESUBMITTED WITH AN ADDITIONAL OR CORRECTED DIAGNOSIS. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 131 | MODIFIER FOR PROCEDURE CODE IS INVALID FOR HOSPITAL PLACE OF SERVICE. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 132 | THE TOTAL CLAIM CHARGE IS ZEROES, OR THE LINE ITEM SUBMITTED CHARGE IS ZEROES. ZERO CHARGES ARE ACCEPTABLE FOR VACCINE REPLACEMENT. | M79 | MISSING/INCOMPLETE/INVALID CHARGE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 133 | THE NDC BILLED IS NOT COVERED BY IOWA MEDICAID. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 204 | THIS SERVICE/EQUIPMENT/DRUG IS NOT COVERED UNDER THE PATIENT'S CURRENT BENEFIT PLA |
| 134 | THE BILLED PROCEDURE REQUIRES A MODIFIER. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 135 | OXYGEN HAS PREVIOUSLY BEEN BILLED FOR DATES OVERLAPPING THIS CLAIM. THESE TWO TYPES OF OXYGEN CANNOT BE BILLED SIMULTANEOUSLY. | M80 | NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 136 | THE CALCULATED CHARGE IS EQUAL TO ZERO OR THE CALCULATED ALLOWED CHARGE IS LESS THAN THE THIRD-PARTY INSURANCE AMOUNT. | N58 | MISSING/INCOMPLETE/INVALID PATIENT LIABILITY AMOUNT. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 137 | CARRIER DENIED COVERAGE. | N598 | HEALTH CARE POLICY COVERAGE IS PRIMARY. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 138 | THE CLAIM DATE OF SERVICE OVERLAPS MULTIPLE RATES ON FILE FOR THIS PROVIDER. | N62 | DATES OF SERVICE SPAN MULTIPLE RATE PERIODS. RESUBMIT SEPARATE CLAIMS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 139 | THE DAYS SUPPLY IS MISSING OR INVALID. | M53 | MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 140 | THE DAYS SUPPLY FOR THE DRUG DISPENSED IS MORE THAN THE MAXIMUM DAYS SUPPLY ALLOWED FOR THE NDC OR THE DAYS SUPPLY IS ZERO. | N378 | MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 141 | THE NDC IS NOT A VALID NDC FOR IOWA MEDICAID BILLING. | M119 | MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 142 | THE 1ST PROCEDURE CODE MODIFIER IS NOT VALID WITH THE PROCEDURE CODE BILLED. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 143 | THE 2ND PROCEDURE CODE MODIFIER IS NOT VALID FOR THE PROCEDURE CODE BILLED. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 144 | THE PROCEDURE BILLED IS NOT A VALID PROCEDURE FOR THIS PROVIDER TYPE. | | ... | 8 | THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 145 | THE DIAGNOSIS AND PROCEDURE BILLED ARE NOT COMPATIBLE. THE DIAGNOSIS MUST REFLECT THE MEDICAL NEED FOR THE PROCEDURE BILLED. | | ... | 11 | THE DIAGNOSIS IS INCONSISTENT WITH THE PROCEDURE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 146 | THE PROCEDURE BILLED IS LIMITED TO A SPECIALTY OTHER THAN THAT OF THE PROVIDER BILLING FOR THE SERVICE. | N95 | THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE. | 8 | THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 147 | THE PROCEDURE CODE BILLED IS NOT VALID FOR THE PROVIDER BILLING THE SERVICE. | N95 | THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE. | 8 | THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 148 | THERE IS A DATE SPAN, AND THE SUBMITTED CHARGES ARE NOT EVENLY DIVISIBLE BY THE UNITS OF SERVICE. | N345 | DATE RANGE NOT VALID WITH UNITS SUBMITTED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 149 | THE REFERRING PROVIDER NAME AND NUMBER ARE REQUIRED. | N286 | MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 150 | THE DIAGNOSIS INDICATES THIS IS A TRAUMA/ACCIDENT CLAIM. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 151 | VACCINE CODES (90471 OR 90472) AND PROCEDURE 90700-90750 MUST BE BILLED TOGETHER (IOWA VACCINE REPLACEMENT PROGRAM) | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). | B15 | THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE ... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 152 | PROCEDURE CODE AND/OR MODIFIER SUBMITTED REQUIRE MANUAL PRICING. INSUFFICIENT DATA WAS PROVIDED TO ALLOW A PRICING DETERMINATION. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 153 | RECHECK CODING AND UNITS. THERE IS A DESCREPANCY BETWEEN THE CODE BILLED, THE CHARGE BILLED AND THE UNITS OF SERVICE BILLED. | M53 | MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 154 | THE TPL DATA INDICATOR IS NOT A VALID VALUE. THE VALID VALUES ARE "Y", "N", OR SPACE. | N245 | INCOMPLETE/INVALID PLAN INFORMATION FOR OTHER INSURANCE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 155 | THE MAXIMUM NUMBER OF SERVICES ALLOWED PER CALENDAR MONTH HAS BEEN EXCEEDED. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 156 | TREATING PROVIDER NUMBER IS MISSING, INVALID OR NOT A PART OF THE BILLING GROUP. | N290 | MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 157 | A PROVIDER PAYMENT RATE WAS NOT FOUND FOR THE DATE OF SERVICE. PLEASE CONTACT PROVIDER SERVICES FOR ASSISTANCE. | N65 | PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF SERVICE/PROVIDER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 158 | THE TREATING PROVIDER NUMBER IS NOT A VALID MEDICAID BILLING NUMBER. | N290 | MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 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/IN APPROPRIATE PLACE OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 162 | FROM/THROUGH DATES CANNOT BE USED FOR THIS PROCEDURE; IF MULTIPLE UNITS ARE BILLED, THEY MUST BE ON SEPARATE LINES. | N63 | REBILL SERVICES ON SEPARATE CLAIM LINES. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 163 | THE TREATING PROVIDER IS A "GROUP." BOTH A GROUP NUMBER AND A TREATING PROVIDER NUMBER MUST BE SHOWN IN THE CORRECT FIELDS. | N290 | MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 164 | THE TREATING PROVIDER IS INELIGIBLE FOR THE DATES OF SERVICE. | N570 | MISSING/INCOMPLETE/INVALID CREDENTIALING DATA. | B7 | THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 165 | ALLOWANCE FOR SURGICAL TRAY HAS BEEN ADDED | | ... | 70 | COST OUTLIER - ADJUSTMENT TO COMPENSATE FOR ADDITIONAL COSTS |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 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/IN APPROPRIATE PLACE OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 171 | MISSING/INCOMPLETE/INVALID CLIA CERTIFICATION NUMBER OR IT IS NOT WITHIN AN EFFECTIVE CLIA DATE RANGE FOR THE LABORATORY SERVICE BILLED. | MA120 | MISSING/INCOMPLETE/INVALID CLIA CERTIFICATION NUMBER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 172 | THE RECIPIENT'S AGE IS NOT WITHIN THE AGE RANGE ALLOWED FOR THE PROCEDURE CODE. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 173 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE PROCEDURE CODE. | | ... | 7 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 174 | THE SERVICE BILLED IS NOT COVERED FOR THIS RECIPIENT. THE RECIPIENT HAS LIMITED COVERAGE FOR EMERGENCY CARE ONLY. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 27 | EXPENSES INCURRED AFTER COVERAGE TERMINATED |
| 175 | THE PROCEDURE CODE OR MODIFIER BILLED IS EITHER INVALID, MISSING OR NONPAYABLE FOR THE DATE OF SERVICE. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 176 | THE REVENUE CODE BILLED IS NOT A VALID REVENUE CODE FOR IOWA MEDICAID. | M50 | MISSING/INCOMPLETE/INVALID REVENUE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 177 | THE PROCEDURE/SERVICE BILLED HAS BEEN DETERMINED TO BE NONCOVERED FOR THE DATE OF SERVICE SHOWN ON THE CLAIM. | N56 | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 178 | THE RECIPIENT IS ENROLLED IN A MEDICAID HMO/MCO. THE SERVICE/DATE IS NOT COVERED UNDER FEE-FOR-SERVICE MEDICAID - THE HMO/MCO MUST BE BILLED. | | ... | 24 | CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN |
| 179 | THE UNITS OF SERVICE ARE EQUAL TO ZERO FOR THE REVENUE CODES 100-219. ROMM AND BOARD UNITS ARE REQUIRED TO SHOW THE NUMBER OF DAYS. | M53 | MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 180 | THE PROCEDURE CODE IS FOR EPSDT SERVICES AND THE RECIPIENT IS 21 OR OLDER. RECIPIENTS OVER AGE 21 ARE NOT ELIGIBLE FOR EPSDT SERVICES. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 181 | THE FIRST DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS FOR IOWA MEDICAID. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 182 | THE FIRST DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 183 | THE DIAGNOSIS BILLED REQUIRES AN ATTACHMENT: STERILIZATION CONSENT FORM, ABORTION CERTIFICATION, HYSTERECTOMY STATEMENT. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 184 | INVALID MODIFIER CODE FOR AN INDEPENDENT LAB PROCEDURE. PLEASE CORRECT AND RESUBMIT CLAIM. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 185 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FIRST DIAGNOSIS CODE. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 186 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FIRST DIAGNOSIS CODE. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 187 | THE DRUG IS LESS THAN EFFECTIVE OR WITHDRAWN FROM THE MARKET. | M119 | MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 188 | THE SECOND DIAGNOSIS CODE IS NOT A VALID DIAGNOSIS FOR IOWA MEDICAID. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 189 | THE SECOND DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 190 | THE DIAGNOSIS BILLED REQUIRES AN ATTACHMENT: STERILIZATION CONSENT FORM, ABORTION CERTIFICATION OR HYSTERECTOMY STATEMENT. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 191 | THE RECIPIENT'S DATE OF DEATH IS BEFORE THE LAST DATE OF SERVICE. | | ... | 13 | THE DATE OF DEATH PRECEDES THE DATE OF SERVICE |
| 192 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE SECOND DIAGNOSIS CODE. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 193 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SECOND DIAGNOSIS CODE. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 194 | PROCEDURE REQUIRES SUPPORTING DOCUMENTATION INCLUDING IDENTIFICATION OF PROCEDURE/SERVICE AND MEDICAL NECESSITY. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 195 | PAY-TO PROVIDER HAS NOT ATTESTED. | N570 | MISSING/INCOMPLETE/INVALID CREDENTIALING DATA. | B7 | THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 196 | THE THIRD DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 197 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 198 | PROCEDURE REQUIRES MEDICAL REVIEW FOR THE DATE OF SERVICE ENTERED. DOCUMENTATION WAS NOT SUFFICIENT TO DETERMINE MEDICAL NECESSITY. | N661 | DOCUMENTATION DOES NOT SUPPORT THAT THE SERVICES RENDERED WERE MEDICALLY NECESSARY. | 50 | THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 199 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE THIRD DIAGNOSIS CODE. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 200 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE THIRD DIAGNOSIS CODE. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 201 | PROVIDER IS INELIGIBLE FOR THE WAIVER TYPE ON CLAIM, PLEASE CORRECT AND RESUBMIT. | N95 | THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE. | 170 | PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 202 | THE FOURTH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 203 | THE FOURTH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 204 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 205 | PROCEDURE NOT APPLICABLE TO APG REIMBURSEMENT. THE GROUPER HAS DENIED THE PROCEDURE BILLED AS NOT APPLICABLE. VERIFY PROCEDURE CODING. | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 206 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FOURTH DIAGNOSIS CODE. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 207 | TRANSACTION SUBMITTED FOR A CREDITED OR DENIED CLAIM, PLEASE RESUBMIT. | N547 | A REFUND REQUEST (FREQUENCY TYPE CODE 8) WAS PROCESSED PREVIOUSLY. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 208 | THE 2ND DIAGNOSIS BILLED REQUIRES MEDICAL REVIEW. DOCUMENTATION PROVIDED DID NOT ESTABLISH MEDICAL NECESSITY. | N661 | DOCUMENTATION DOES NOT SUPPORT THAT THE SERVICES RENDERED WERE MEDICALLY NECESSARY. | 50 | THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 209 | THE PLACE OF SERVICE BILLED IS NOT A VALID PLACE OF SERVICE FOR PHYSICIAN ASSISTANT SERVICES. | M77 | MISSING/INCOMPLETE/INVALID/IN APPROPRIATE PLACE OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 210 | THE FIFTH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 211 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 212 | THE 3RD DIAGNOSIS CODE REQUIRES MEDICAL REVIEW . | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 213 | DUPLICATE CASE MANAGEMENT SERVICES WERE RECEIVED FOR THE CALENDAR MONTH. | | ... | 18 | EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO |
| 214 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FIFTH DIAGNOSIS CODE. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 215 | THE 4TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW . | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 216 | THE SIXTH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 217 | THE SIXTH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 218 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 219 | THE 5TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW . | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 220 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE SIXTH DIAGNOSIS CODE. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 221 | THE RECIPIENT IS A QUALIFIED MEDICARE BENEFICIARY AND IS ELIGIBLE ONLY FOR PAYMENT OF COINSURANCE AND DECUTIBLES ON MEDICARE COVERED SERVICES. | N479 | MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 222 | THE 6TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW . | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 223 | RECIPIENT IS NOT ELIGIBLE FOR THE WAIVER TYPE BILLED FOR THE CLAIM DATES OF SERVICE OR THE WAIVER TYPE IS MISSING OR INVALID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 224 | A VALID MODIFIER FOR CRNA SERVICES WAS NOT BILLED. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 225 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 226 | THE 7TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW . | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 227 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE SEVENTH DIAGNOSIS CODE. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 228 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SEVENTH DIAGNOSIS CODE. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 229 | THE PRIOR AUTHORIZATION REASON CODE IS MISSING OR NOT ON FILE. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 197 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT |
| 230 | THE SERVICE/ITEM BILLED REQUIRES PRIOR AUTHORIZATION. THERE IS NO PRIOR AUTHORIZATION FOR ALL OR PART OF THIS DATE SPAN BILLED. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 197 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 231 | INVALID OR MISSING PATIENT MANAGER REFERRAL NUMBER FOR THIS RECIPIENT. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 197 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT |
| 232 | THE PROCEDURE CODE REQUIRES A PRIOR AUTHORIZATION NUMBER AND THE RECIP- IENT ON THE CLAIM DOES MATCH THE RECIPIENT ID ON THE PA. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 284 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES |
| 233 | THE PROCEDURE CODE REQUIRES A PRIOR AUTHORIZATION NUMBER AND THE MODIFIER ON THE CLAIM DOES NOT MATCH THE MODIFIER ON THE PA. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 284 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES |
| 234 | PROVIDER CANNOT MEDICALLY DIRECT A CRNA. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 197 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT |
| 235 | THE LEVEL OF CARE INDICATOR IS MISSING OR INVALID. | N188 | THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 236 | HOSPICE REVENUE CODE NUMBER OF HOURS (UNITS) IS BELOW THE REQUIRED 8 HOURS OF SERVICE PER DAY. | M53 | MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 237 | THE PROCEDURE CODE REQUIRES A PRIOR AUTHORIZATION AND THE PROCE- DURE CODE ON THE CLAIM DOES NOT MATCH THE PROCEDURE CODE ON THE PA. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 284 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES |
| 238 | THIS SERVICE/ITEM REQUIRED A PRIOR AUTHORIZATION. THE DATE OF SERVICE ON THE CLAIM ARE NOT WITHIN THE DATE RANGE OF THE PRIOR AUTHORIZATION. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 284 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 239 | THE PROCEDURE CODE REQUIRES A PRIOR AUTHORIZATION NUMBER AND THE LINE ITEM ON THE CLAIM IS NOT APPROVED. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 39 | SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED |
| 240 | RECIPIENT ELIGIBIITY RECORD DOES NOT SHOW THE BILLING PROVIDER AS THE CORRECT PROVIDER FOR THE DATE OF SERVICE ON THE CLAIM. CONTACT DHS. | N54 | CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 241 | THE PRIOR AUTHORIZATION HAS BEEN USED. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 198 | PRECERTIFICATION/NOTIFICATION/AUTHORIZATION/PRE-TREATMENT EXCEEDED |
| 242 | THE RECIPIENT IS 65 OR OLDER AND NO MEDICARE COVERAGE IS PRESENT ON THE RECIPIENT FILE. | N479 | MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 243 | IOWA MEDICAID HAS NOT ESTABLISHED A FEE FOR THIS PROCEDURE AND THE ALLOWED AMOUNT ON THE PRIOR AUTHORIZATION IS ZERO. | N65 | PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF SERVICE/PROVIDER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 244 | THE 8TH DIAGNOSIS CODE REQUIRES MEDICAL REVIEW . | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 245 | THE COVERED DAYS BILLED WERE REDUCED TO THE NUMBER OF DAYS OF MEDICAID ELIGIBILITY. | | ... | 239 | CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE. REBILL SEPARATE CLAIMS |
| 246 | THE RECIPIENT WAS NOT ELIGIBLE FOR MEDICAID FOR THE ENTIRE DATE SPAN BILLED. | | ... | 239 | CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE. REBILL SEPARATE CLAIMS |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 247 | RECIPIENT GUARDIAN INFORMATION IS NOT ON RECIPIENT FILE FOR DOS. PLEASE CONTACT LOCAL COUNTY OFFICE TO VERIFY GUARDIAN INFORMATION. | N77 | MISSING/INCOMPLETE/INVALID DESIGNATED PROVIDER NUMBER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 248 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 249 | MORE THAN 20 CLAIMS HAVE BEEN SUBMITTED FOR THIS RECIPIENT, CLAIMS WILL BE PROCEESSED IN THE NEXT CYCLE. | | ... | 133 | THE DISPOSITION OF THIS SERVICE LINE IS PENDING FURTHER REVIEW. (USE ONLY WITH GROUP CODE OA). USAGE: USE OF THIS CODE REQUIRES A REVERSAL AND CORRECTION WHEN THE SERVICE LINE IS FINALIZED (USE ONLY IN LOOP 2110 CAS SEGMENT OF THE 835 OR LOOP 2430 OF ... |
| 250 | DRG IS NOT VALID FOR THE DATES OF SERVICE ON CLAIM. TYPE OF BILL OR DIAGNOSIS/PROCEDURE CODE(S) MAY BE INVALID. | | ... | A8 | UNGROUPABLE DRG |
| 251 | THE RECIPIENT NUMBER IS NOT ON THE ELIGIBILITY FILE. VERIFY CORRECT RECIPIENT ID NUMBER AND RESUBMIT CLAIM WITH VALID NUMBER. | | ... | 31 | PATIENT CANNOT BE IDENTIFIED AS OUR INSURED |
| 252 | THE DHS ELIGIBILITY RECORD IS NOT SHOWING APPROVAL FOR THIS FACILITY FOR THIS DATE OF SERVICE. | N188 | THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 253 | THE NINTH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 254 | THE NINTH DIAGNOSIS CODE IS NOT COVERED BY MEDICAID. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 255 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 256 | THE RECIPIENT HAS MEDICARE COVERAGE ACCORDING TO DHS RECORDS. MEDICARE MUST BE BILLED FOR THE SERVICE. MEDICAID WILL PAY CROSS-OVER CLAIM ONLY | N479 | MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 257 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE NINTH DIAGNOSIS CODE. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 258 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE NINTH DIAGNOSIS CODE. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 259 | THE SERVICE IS NOT COVERED FOR IOWA HEALTH AND WELLNESS PLAN MEMBERS. HMO/MARKETPLACE MUST BE BILLED FOR MEMBERS ASSIGNED TO THEM. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 109 | CLAIM/SERVICE NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 \| LAST MODIFIED: 01/29/2012... |
| 260 | THE FIRST SURGICAL PROCEDURE CODE IS NOT A VALID CODE FOR MEDICAID. | MA66 | MISSING/INCOMPLETE/INVALID PRINCIPAL PROCEDURE CODE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 261 | THE FIRST SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID. | N56 | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 262 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 263 | ABORTIONS, STERILIZATIONS, AND HYSTERECTOMIES MUST BE SUBMITTED WITH PROPER DOCUMENTATION FOR MANUAL REVIEW. | N66 | MISSING/INCOMPLETE/INVALID DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 264 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FIRST SURGICAL PROCEDURE CODE. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 265 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FIRST SURGICAL PROCEDURE CODE. | | ... | 7 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 266 | THE FIRST SURGICAL PROCEDURE CODE REQUIRES PRIOR AUTHORIZATION AND THE PRIOR AUTHORIZATION NUMBER IS ZEROES. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 284 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT NUMBER MAY BE VALID BUT DOES NOT APPLY TO THE BILLED SERVICES |
| 267 | THE SECOND SURGICAL PROCEDURE CODE IS NOT ON THE PROCEDURE FILE. | M67 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 268 | THE SECOND SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID. | N56 | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 269 | TOTAL UNITS FOR REVENUE CODES 655 AND 658 EXCEED THE TOTAL NUMBER OF DAYS BILLED ON THE CLAIM FORM. | N345 | DATE RANGE NOT VALID WITH UNITS SUBMITTED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 270 | THE RECIPIENT IS NOT ELIGIBLE FOR MEDICAID ON THE DATE OF SERVICE BILLED | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 26 | EXPENSES INCURRED PRIOR TO COVERAGE |
| 271 | THE RECIPIENT IS INELIGIBLE FOR THE DATE OF SERVICE. THE CLAIM WILL PEND TEMPORARILY TO ALLOW FOR ELIGIBILITY FILE UPDATES FROM DHS. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 26 | EXPENSES INCURRED PRIOR TO COVERAGE |
| 272 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SECOND SURGICAL PROCEDURE CODE. | | ... | 7 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 273 | THE RECIPIENT IS NOT ELIGIBLE FOR MEDICAID ON EITHER ALL OR A PORTION OF THE DATES OF SERVICE BILLED. | | ... | 238 | CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE, THIS IS THE REDUCTION FOR THE INELIGIBLE PERIOD. (USE ONLY WITH GROUP CODE PR |
| 274 | THE THIRD SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID. | N56 | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 275 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 276 | THE TOOTH NUMBER OR LETTER IS INVALID. PLEASE CORRECT AND RESUBMIT THE CLAIM. | N37 | MISSING/INCOMPLETE/INVALID TOOTH NUMBER/LETTER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 277 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE THIRD SURGICAL PROCEDURE CODE. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 278 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE THIRD SURGICAL PROCEDURE CODE. | | ... | 7 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 279 | THE FOURTH SURGICAL PROCEDURE CODE IS NOT ON THE PROCEDURE FILE. | M67 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 280 | THE FOURTH SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID. | N56 | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 281 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 282 | THERE IS AN ADJUSMENT IN PROCESS FOR THIS CLAIM. | N522 | DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM. | 18 | EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO |
| 283 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FOURTH SURGICAL PROCEDURE CODE. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 284 | DUPLICATE OF A CLAIM PREVIOUSLY USED TO MEET MEDICALLY NEEDY SPENDDOWN. | N522 | DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM. | 18 | EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO |
| 285 | THE FIFTH SURGICAL PROCEDURE CODE IS NOT ON THE PROCEDURE FILE. | M67 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 286 | THE FIFTH SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID. | N56 | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 287 | ABORTION, STERILIZATION, OR HYSTERECTOMY CONSENT FORM IS MISSING OR INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 288 | DHS RECORDS DO NOT SHOW A MATCHING NURSING FACILITY RECORD FOR THE FULL DATE RANGE.THIS RECORD MUST BE PRESENT FOR CLAIM PAYMENT TO BE MADE. | N54 | CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 289 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE FIFTH SURGICAL PROCEDURE CODE. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 290 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE FIFTH SURGICAL PROCEDURE CODE. | | ... | 7 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 291 | THE ADMIT DATE CONFLICTS WITH THE DATE OF SERVICE. | MA40 | MISSING/INCOMPLETE/INVALID ADMISSION DATE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 292 | THE SIXTH SURGICAL PROCEDURE CODE IS NOT COVERED BY IOWA MEDICAID. | N56 | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 293 | THIS SERVICE IS AN EXACT DUPLICATE OF A SERVICE USED TO MEET MEDICALLY NEEDY SPEND DOWN. THESE CHARGES ARE THE LIABILITY OF THE RECIPIENT. | N522 | DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM. | 18 | EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO |
| 294 | THE DISCHARGE STATUS IS NOT VALID FOR THE TYPE OF CLAIM BILLED. | N50 | MISSING/INCOMPLETE/INVALID DISCHARGE INFORMATION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 295 | THIS SERVICE REPRESENTS A DUPLICATION OR OVERLAP OF SERVICES PROVIDED BY THE SAME OR A DIFFERENT PROVIDER THAT WAS APPLIED TOWARDS SPENDDOWN. | N522 | DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM. | 18 | EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 296 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE SIXTH SURGICAL PROCEDURE CODE. | | ... | 7 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 297 | CLAIM DOES NOT MEET MEDICAID PROVIDER MANUAL CRITERIA. CLAIM CAN BE RESUBMITTED IF ADDITIONAL DOCUMENTATION OF MEDICAL NECESSITY IS PROVIDED | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 298 | UNLISTED CODES REQUIRE REPORT ATTACHED TO CLAIM EXPLAINING WHAT SERVICE WAS PROVIDED. PLEASE BE SURE CORRECT CODE WAS BILLED. | N350 | MISSING/INCOMPLETE/INVALID DESCRIPTION OF SERVICE FOR A NOT OTHERWISE CLASSIFIED (NOC) CODE OR FOR AN UNLISTED/BY REPORT PROCEDURE. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 299 | THE PRESCRIBING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE DME UNDER IOWA MEDICAID POLICY. | | ... | 184 | THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 300 | THIS SVC CANNOT BE BILLED BY THIS PROV TYPE ON THIS CLM FORM FOR THIS DATE OF SVC.(IHS,CHECK IF MEMB IS NOT NATIVE AMERICAN INDIAN) | N34 | INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 301 | THE DAYS SUPPLIED EXCEEDS THE MAXIMUM ALLOWED. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 302 | ONLY ONE CHARGE CAN BE BILLED PER MONTH FOR EACH APPROVED SERVICE. ONE CHARGE MUST BE BILLED SHOWING ALL UNITS FOR THE MONTH. | M53 | MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 303 | THE "E" DIAGNOSIS CODE CANNOT BE BILLED AS A PRIMARY DIAGNOSIS ON THE UB 04 CLAIM FORM. "E" DIAGNOSIS CODES CANNOT BE USED ON THE HCFA 1500. | MA63 | MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 304 | YOUR LICENSE HAS EXPIRED. PLEASE SEND COPY OF CURRENT RENEWAL. | M143 | THE PROVIDER MUST UPDATE LICENSE INFORMATION WITH THE PAYER. | 170 | PAYMENT IS DENIED WHEN PERFORMED/BILLED BY THIS TYPE OF PROVIDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 305 | THE LAST X-RAY DATE IS TOO OLD. THE MEDICAID PROVIDER MANUAL LISTS MEDICAID X-RAY REQUIREMENTS. | M1 | X-RAY NOT TAKEN WITHIN THE PAST 12 MONTHS OR NEAR ENOUGH TO THE START OF TREATMENT. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 306 | THE ACCIDENT DATE IS NOT VALID. PLEASE CORRECT AND RESUBMIT THE CLAIM. | N305 | MISSING/INCOMPLETE/INVALID INJURY/ACCIDENT DATE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 307 | A MINIMUM OF 8 HOURS PER DAY MUST BE BILLED. | M53 | MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 308 | MEDICAL VISITS CANNOT BE BILLED SEPARATELY FROM A MAJOR SURGICAL PROCEDURE. THIS IS CONSIDERED NORMAL PRE/POST OPERATIVE CARE. | M144 | PRE-/POST-OPERATIVE CARE PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE SURGERY/PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 309 | DRG NOT ON FILE. | | ... | A8 | UNGROUPABLE DRG |
| 310 | THE ADJUSTMENT TCN DATE IS OVER 365 DAYS FROM THE ORIGINAL PAID DATE OF THE CLAIM TO BE ADJUSTED/CREDITED. | | ... | 29 | THE TIME LIMIT FOR FILING HAS EXPIRED |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 311 | CROSSOVER CLAIM RECEIVED WITH NO MEDICARE ALLOWED AMOUNT, DEDUCTIBLE, AND COINSURANCE AMOUNT. PLEASE SUBMIT UB04 FOR PAYMENT CONSIDERATION. | N58 | MISSING/INCOMPLETE/INVALID PATIENT LIABILITY AMOUNT. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 312 | UNITS EXCEEDED MAXIMUM UNITS ALLOWED FOR PARTIAL HOSPITAL. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 313 | UNITS SUBMITTED EXCEED THE MAXIMUM UNITS ALLOWED FOR DAY TREATMENT. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 314 | DIAGNOSIS INDICATES SUBSTANCE ABUSE. THE SERVICE SHOULD BE BILLED TO THE SUBSTANCE ABUSE CONTRACTOR. | | ... | 24 | CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN |
| 315 | CASE MANAGEMENT SERVICES ARE PAYABLE BY MENTAL HEALTH CONTRACTOR FOR THIS RECIPIENT. | | ... | 24 | CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN |
| 316 | NO APG WEIGHT ASSIGNED FOR PROCEDURE BILLED. | N65 | PROCEDURE CODE OR PROCEDURE RATE COUNT CANNOT BE DETERMINED, OR WAS NOT ON FILE, FOR THE DATE OF SERVICE/PROVIDER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 317 | COVERED DAYS ARE MISSING OR INVALID. | MA32 | MISSING/INCOMPLETE/INVALID NUMBER OF COVERED DAYS DURING THE BILLING PERIOD. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 318 | RECHECK ACCIDENT/SERVICE DATE. ACCIDENT DATE IS SHOWN AFTER THE DATE OF SERVICE OR IS AN INVALID DATE. | N305 | MISSING/INCOMPLETE/INVALID INJURY/ACCIDENT DATE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 319 | INVALID LEVEL OF CARE, PLEASE CORRECT AND RESUBMIT CLAIM. | N188 | THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 320 | THE CONDITION CODE BILLED IS NOT A VALID CONDITION CODE PER UB 04 MANUAL. | M44 | MISSING/INCOMPLETE/INVALID CONDITION CODE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 321 | PHARMACY CHARGES MUST BE BILLED ON THE UNIVERSL PHARMACY CLAIM FORM. TAKE-HOME SUPPLIES MUST BE BILLED ON A HCFA 1500 CLAIM. | N34 | INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 322 | SUPPLY/EQUIPMENT CHARGES MUST BE BILLED ON THE HCFA 1500 CLAIM FORM UNDER A DEALER PROVIDER NUMBER. | N34 | INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 323 | THE BILLING PROVIDER IS NOT CERTIFIED TO PROVIDE THE SERVICE BEING SUBMITTED. | N570 | MISSING/INCOMPLETE/INVALID CREDENTIALING DATA. | B7 | THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 324 | MULTIPLE OUTPATIENT SERVICES WITHIN 72 HOURS FOR A RELATED CONDITION MUST BE SUBMITTED ON THE SAME CLAIM. A PREVIOUS CLAIM HAS BEEN PAID. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 325 | CANNOT PROCESS THIS CLAIM BECAUSE OF TOO MANY ERRORS. CONTACT THE PROVIDER RELATIONS DEPARTMENT FOR ASSISTANCE. | | ... | 95 | PLAN PROCEDURES NOT FOLLOWED |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 326 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE EIGHTH DIAGNOSIS CODE. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 327 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE SECOND SURGICAL PROCEDURE CODE. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 328 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE EIGHTH DIAGNOSIS CODE. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 329 | TRANSACTION SUBMITTED WITH UNIDENTIFIABLE ELEMENTS OR NOT WITHIN ONE YEAR OF PAID DATE | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 330 | THE LINE ITEM DATE OF SERVICE IS NOT WITHIN THE COVERED DATES. CORRECT THE DATE OF SERVICE AND RESUBMIT. | N301 | MISSING/INCOMPLETE/INVALID PROCEDURE DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 331 | THE CLAIM DATE OF SERVICE IS TOO OLD TO PROCESS. TIMELY FILING GUIDELINES WERE NOT MET. | | ... | 29 | THE TIME LIMIT FOR FILING HAS EXPIRED |
| 332 | THIS IS NOT A PROCEDURE ON THE APPROVED LIST OF ASC SURGICAL SERVICES. | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 333 | AN OUTPATIENT CLAIM CANNOT BE BILLED WITHIN 72 HOURS OF AN INPATIENT CLAIM FROM THE SAME FACILITY. CHARGES MUST BE COMBINED. | | ... | 60 | CHARGES FOR OUTPATIENT SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN A PERIOD OF TIME PRIOR TO OR AFTER INPATIENT SERVICES |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 334 | PROVIDER IS INELIGIBLE TO BILL FOR SPECIAL CHILD ABUSE PROCEDURE CODES. | N570 | MISSING/INCOMPLETE/INVALID CREDENTIALING DATA. | B7 | THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 335 | THE CLAIM EXCEEDS THE LINE ITEM THRESHOLD ALLOWED BY MEDICAID. | N61 | REBILL SERVICES ON SEPARATE CLAIMS. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 336 | THE "E" DIAGNOSIS CODE CANNOT BE USED AS THE PRIMARY DIAGNOSIS. | MA63 | MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 337 | INVALID PROCEDURE CODE FOR APG GROUPER - THE GROUPER DID NOT ACCEPT THE PROCEDURE CODE BILLED AS A VALID OUTPATIENT CODE FOR THIS DATE. | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 338 | A CHARGE CANNOT BE SUBMITTED FOR BOTH A PANORAMIC X-RAY AND A COMPLETE INTRA-ORAL SERIES. | N20 | SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 339 | ADJUSTMENT SUBMITTED ON A DENIED CLAIM. PLEASE RESUBMIT AS A NEW CLAIM. | N142 | THE ORIGINAL CLAIM WAS DENIED. RESUBMIT A NEW CLAIM, NOT A REPLACEMENT CLAIM. | A1 | CLAIM/SERVICE DENIED. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT. |
| 340 | PRESCRIBING/ORDERING/REFERRING PROVIDER NOT ENROLLED WITH IOWA MEDICAID AS REQUIRED BY THE AFFORDABLE CARE ACT. | | ... | 183 | THE REFERRING PROVIDER IS NOT ELIGIBLE TO REFER THE SERVICE BILLED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 341 | AN INVALID LEVEL OF CARE OR TERMINATION CODE WAS BILLED BASED ON THE FACILITY RECORD OF THE RECIPIENT. | N188 | THE APPROVED LEVEL OF CARE DOES NOT MATCH THE PROCEDURE CODE SUBMITTED. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 342 | MULTIPLE OP PROCEDURES PERFORMED WITHIN 72 HOURS SHOULD BE SUBMITTED ON THE SAME CLAIM FORM. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 343 | CLAIM SUBMITTED AS A CROSSOVER. MEMBER DOES NOT HAVE MEDICARE. | N34 | INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 344 | THE MAXIMUM NUMBER OF STRESS TESTS ALLOWED HAS BEEN EXCEEDED. IF UNUSUAL CIRCUMSTANCES ARE DOCUMENTED, MEDICAL REVIEW CAN BE REQUESTED. | N435 | EXCEEDS NUMBER/FREQUENCY APPROVED /ALLOWED WITHIN TIME PERIOD WITHOUT SUPPORT DOCUMENTATION. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 345 | MEMBER IS NOT CERTIFIED FOR HOSPICE SERVICE | M46 | MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 346 | REV CODE 001 MUST BE SUBMITTED ON LINE 23 OF UB04 | M50 | MISSING/INCOMPLETE/INVALID REVENUE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 347 | THE REVENUE CODE BILLED IS NOT A VALID REVENUE CODE AS SHOWN IN THE UB04 BILLING MANUAL OR THE REVEUNE CODE IS NOT ALLOWED FOR PROVIDER TYPE. | M50 | MISSING/INCOMPLETE/INVALID REVENUE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 348 | CLAIM SHOWS CONFLICTING MEDICARE EXHAUST DATE WITH BILLNG DATE. | MA31 | MISSING/INCOMPLETE/INVALID BEGINNING AND ENDING DATES OF THE PERIOD BILLED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 349 | THE SERVICE LIMIT FOR THIS ITEM OR SERVICE HAS BEEN EXCEEDED. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 350 | CLAIM DENIED. THE SYSTEM CALCULATED A NUMBER THAT IS TOO LARGE FOR THE FIELD WHICH IS BEING CALCULATED. PLEASE VERIFY YOUR UNITS AND RESUBMIT. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 351 | PROCEDURE CODE, REV CODE, DIAGNOSIS COMBINATION IS NOT COVERED FOR MEMBER. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 256 | SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT |
| 352 | CONTINUOUS HOME CARE MUST BE PROVIDED WITH A MINIMUM OF 8 HOURS PER DAY. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 353 | THE PROCEDURE CODE BILLED IS NOT A VALID PROCEDURE CODE FOR IA MEDICAID OR FOR FQHC/RHC/IHS T1015/D9999 IS NOT BILLED ON THE FIRST LINE. | N95 | THIS PROVIDER TYPE/PROVIDER SPECIALTY MAY NOT BILL THIS SERVICE. | 8 | THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE/SPECIALTY (TAXONOMY). USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 354 | THE RECIPIENT IS NOT ELIGIBLE FOR TARGETED CASE MANAGEMENT SERVICES BASED ON RECORDS PROVIDED BY DHS. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 355 | RECIPIENT IS LOCKED IN TO A SPECIFIC PROVIDER. THE PROVIDER BILLING IS NOT THE LOCK-IN PROVIDER. | N450 | COVERED ONLY WHEN PERFORMED BY THE PRIMARY TREATING PHYSICIAN OR THE DESIGNEE. | 242 | SERVICES NOT PROVIDED BY NETWORK/PRIMARY CARE PROVIDERS |
| 356 | NO DRUG PRICING SEGMENT FOR THE DATE OF SERVICE OR OBSOLETE DRUG | M119 | MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 357 | YOU HAVE BILLED A DATE SPAN THAT INDICATES A RENTAL, BUT YOU DID NOT BILL WITH THE RENTAL MODIFIER (RR). PLEASE CORRECT CLAIM AND RESUBMIT. | | ... | 108 | RENT/PURCHASE GUIDELINES WERE NOT MET. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 358 | THE SERVICE IS NOT COVERED FOR MARKETPLACE MEMBERS. HMO/MARKETPLACE MUST BE BILLED FOR MEMBERS ASSIGNED TO THEM. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 109 | CLAIM/SERVICE NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 \| LAST MODIFIED: 01/29/2012... |
| 359 | MISSING OR INCOMPLETE DOCUMENTATION | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 360 | THERE IS A CONFLICT BETWEEN THE DATES OF SERVICE BILLED AND THE UNITS OF SERVICE BILLED. | M53 | MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 361 | SERVICE LIMIT EXCEEDED FOR BILLED SERVICE. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 362 | MULTIPLE DENTAL EXAMS HAVE BEEN BILLED FOR THIS RECIPIENT ON THIS DATE. THIS IS PAYABLE ONLY IF EACH DENTIST HAS A DIFFERENT SPECIALTY. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | B14 | ONLY ONE VISIT OR CONSULTATION PER PHYSICIAN PER DAY IS COVERED |
| 363 | DENTAL CONSULTATIONS ARE LIMITED TO 1 PER YEAR FOR EACH RECIPIENT. ADDITIONAL CONSULTATIONS MUST BE BILLED AS AN EVALUATION. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 364 | EMERGENCY ORAL EXAM CANNOT BE BILLED WITH TREATMENT. CODE D0140/00140 CANNOT BE BILLED IN ADDITION TO OTHER TREATMENT SERVICCES. | N20 | SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 365 | THE PROCEDURE CODE CANNOT BE PERFORMED IN THE PLACE OF SERVICE BILLED UNDER IOWA MEDICAID POLICY. | N428 | NOT COVERED WHEN PERFORMED IN THIS PLACE OF SERVICE. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 366 | CLAIMS ARE REQUIRED TO BE FILED ELECTRONICALLY. | M117 | NOT COVERED UNLESS SUBMITTED VIA ELECTRONIC CLAIM. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 367 | THE SERVICE LIMIT FOR THIS PROCEDURE HAS BEEN EXCEEDED. IF PROSTHETIC WAS LOST, STOLEN, OR BROKEN BEYOND REPAIR, THIS MUST BE DOCUCMENTED. | | ... | 273 | COVERAGE/PROGRAM GUIDELINES WERE EXCEEDED |
| 368 | CLAIM DATE OF SERVICE EXCEEDS TIMELY FILING LIMITS. | | ... | 29 | THE TIME LIMIT FOR FILING HAS EXPIRED |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 369 | NO GUARDIAN RECORD ON FILE. | MA75 | MISSING/INCOMPLETE/INVALID PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 370 | OXYGEN HAS BEEN PREVIOUSLY BILLED FOR THE SAME OR OVERLAPPING SERVICE DATES. | | ... | 18 | EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO |
| 372 | THIS BILLING EXCEEDS THE MAXIMUM ALLOWED FOR DME RENTAL - EITHER MULTIPLE RENTALS PER MONTH OR RENTAL EXCEEDS 100% OF PURCHASE PRICE. | N370 | BILLING EXCEEDS THE RENTAL MONTHS COVERED/APPROVED BY THE PAYER. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 374 | THE SERVICE BILLED ON THIS LINE REPRESENT A CHARGE NOT COVERED BY MEDICARE. COVERED SERVICES MUST BE BILLED ON A MEDICAID CLAIM. | N34 | INCORRECT CLAIM FORM/FORMAT FOR THIS SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 376 | THE RECIPIENT'S AGE IS OUTSIDE THE COVERED AGE RANGE FOR MENTAL HEALTH INSTITUTES. | N129 | NOT ELIGIBLE DUE TO THE PATIENT'S AGE. | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 377 | THE COVERED DAYS FOR PMIC OR MHI IS GREATER THAN 31 DAYS. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 380 | A BITEWING X-RAY CANNOT BE BILLED SEPARATELY IN ADDITION TO A COMPLETE INTRA-ORAL SERIES. | M80 | NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 381 | THE MEDICARE ALLOWED AMOUNT IS ZERO. THE MEDICAID PAYABLE AMOUNT IS COINSURANCE AND DEDUCTIBLE ON MEDICARE COVERED SERVICES. | N480 | INCOMPLETE/INVALID EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 382 | MULTIPLE PROCEDURE PAYMENT REDUCTION APPLIED | | ... | 59 | PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES. (FOR EXAMPLE MULTIPLE SURGERY OR DIAGNOSTIC IMAGING, CONCURRENT ANESTHESIA.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PR... |
| 383 | POA INDICATOR OF N AND/OR U. CLAIM HAS OUTLIER AND NO NON-COVERED CHARGES AND/OR NON-COVERED DAYS. REFER TO IL | MA33 | MISSING/INCOMPLETE/INVALID NON-COVERED DAYS DURING THE BILLING PERIOD. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 384 | MISSING/INCOMPLETE/INVALID PRESENT ON ADMISSION INDICATOR. | N434 | MISSING/INCOMPLETE/INVALID PRESENT ON ADMISSION INDICATOR. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 385 | THE MAXIMUM UNITS FOR FOR THIS ITEM HAS BEEN EXCEEDED. | | ... | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 388 | THE WRONG CIRCUMCISION CODE WAS BILLED FOR A NEWBORN INFANT. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 389 | THE RECIPIENT ID NUMBER ON THE CLAIM IS NOT ON FILE. CORRECT RECIPIENT ID NUMBER AND RESUBMIT YOUR CLAIM. | | ... | 31 | PATIENT CANNOT BE IDENTIFIED AS OUR INSURED |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 390 | A REFRACTION AND AN EYE EXAM OR OTHER EVALUATION/MANAGEMENT SERVICE ARE NOT PAYABLE SEPARATELY ON THE SAME DATE OF SERVICE. | N20 | SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 392 | NO SUPPORTING LINES ARE PRESENT ON THE CLAIM TO SHOW WHICH SERVICES WERE RENDERED WHEN SUBMITTED BY FQHC/RHC/IHS. | M67 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 393 | PROCEDURE/MAXIMUM UNITS CONFLICT. THE NUMBER OF UNITS BILLED EXCEEDS THE NUMBER OF UNITS ROUTINELY ALLOWED FOR THIS SERVICE. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 395 | THE SERVICE BILLED REQUIRES MANUAL PRICING. PLEASE RESUBMIT A PAPER CLAIM WITH DOCUMENTATION ATTACHED. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 397 | A RURAL/INDIAN HEALTH VISIT AND A PHYSICIAN VISIT ARE NOT PAYABLE ON THE SAME DATE BY PROVIDERS AT THE SAME FACILITY. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 400 | THE SERVICE LIMIT FOR THE ITEM OR SERVICE BILLED HAS BEEN EXCEEDED. THE MAXIMUM NUMBER OF UNITS ALLOWED HAS BEEN PREVIOUSLY PAID. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 401 | THIS SERVICE IS COVERED BY IOWA PLAN. | | ... | 24 | CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN |

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 428 | THE MAXIMUM NUMBER OF SERVICE UNITS HAS BEEN EXCEEDED FOR A THREE- MONTH TIME PERIOD. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 429 | APG GROUPER EDIT - THE PROCEDURE BILLED IS DESIGNATED AS INPATIENT AND CANNOT BE BILLED ON AN OUTPATIENT CLAIM. | MA30 | MISSING/INCOMPLETE/INVALID TYPE OF BILL. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 430 | A SCREENING PHYSICAL INCLUDES A HEARING TEST; THEREFORE A HEARING TEST AND A SCREENING PHYSICAL CANNOT BE BILLED SEPARATELY. | N19 | PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 431 | CODES 59425/59426 ARE ONLY PAYABLE ONCE PER PREGNANCY WHEN THE CLAIM DOCUMENTS THAT THIS DR./CLINC WILL NOT BE BILLING OB DELIVERY. | N525 | THESE SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN THE GLOBAL PERIOD OF ANOTHER SERVICE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 432 | THE CLAIM REQUIRES AN ATTACHMENT - THE HYSTERECTOMY STATEMENT, STERILIZATION CONSENT OR ABORTION CERTIFICATION IS MISSING/INCOMPLETE. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 433 | FRAGMENTED SERVICES WERE BILLED ON THE SAME DATE OF SERVICE FOR THIS RECIPIENT.THIS IS PART OF A SERVICE PREVIOUSLY PAID. | M80 | NOT COVERED WHEN PERFORMED DURING THE SAME SESSION/DATE AS A PREVIOUSLY PROCESSED SERVICE FOR THE PATIENT. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 434 | OUTPATIENT MENTAL HEALTH TREATMENT LIMITATION HAS BEEN PHASED OUT BY MEDICARE. PLEASE REFER TO IL 1486. | N480 | INCOMPLETE/INVALID EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 484 | THE RECIPIENT IS ENROLLED IN THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE). SERVICE NOT COVERED UNDER FEE-FOR-SERVICE MEDICAID. | | ... | 24 | CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN |
| 485 | LANGUAGE SERVICE CODE MUST BE BILLED WITH A PAYABLE MEDICAID SERVICE. | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). | B15 | THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SERVICE/PROCEDURE BE RECEIVED AND COVERED. THE QUALIFYING OTHER SERVICE/PROCEDURE HAS NOT BEEN RECEIVED/ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE ... |
| 490 | THE SEVENTH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 499 | INVALID OR MISSING PATIENT MANAGER REFERRAL FOR RECIPIENT | N286 | MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 500 | THERE IS NO RECORD OF AN APPROVED CASE PLAN FOR THIS SERVICE ON THIS DATE. CONTACT DHS FOR UPDATES OF SERVICES APPROVED ON CASE PLAN. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 197 | PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT |
| 501 | THE PRIOR AUTHORIZATION SUBMITTED FOR THIS SERVICE WAS NOT APPROVED. | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 39 | SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED |
| 503 | THE HCPCS PROCEDURE CODE IS NOT A VALID CODE FOR OUTPATIENT CLAIMS. | | ... | 5 | THE PROCEDURE CODE/TYPE OF BILL IS INCONSISTENT WITH THE PLACE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 504 | REVENUE CODE 187 CANNOT BE BILLED FOR DATES OF SERVICE PRIOR TO JULY 1, 2000. | M50 | MISSING/INCOMPLETE/INVALID REVENUE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 505 | THE SURGERY BILLED IS A NON-PAYABLE COSMETIC SURGERY. | N383 | NOT COVERED WHEN DEEMED COSMETIC. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 506 | INVALID DATA IS CONTAINED IN THE CARRIER DENIED COVERAGE FIELD. | N48 | CLAIM INFORMATION DOES NOT AGREE WITH INFORMATION RECEIVED FROM OTHER INSURANCE CARRIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 507 | THE SURGICAL PROCEDURE CODE (10000-69999) REQUIRES A REVENUE CODE OF 36X, 45X, 49X OR 76X. | | ... | 199 | REVENUE CODE AND PROCEDURE CODE DO NOT MATCH |
| 508 | THE REVENUE CODES 36X OR 49X REQUIRE A HCPCS PROCEDURE CODE. | M20 | MISSING/INCOMPLETE/INVALID HCPCS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 510 | THE BILLING PROVIDER IS NOT THE PROVIDER THAT WAS AUTHORIZED TO PERFORM THE SERVICE ON THE PRIOR AUTHORIZATION. | N54 | CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 511 | THE SERVICE BILLED SHOWS A PROCEDURE CODE OR PROVIDER NUMBER THAT WAS NOT SHOWN ON THE CARE PLAN. THE CARE PLAN AND THE CLAIM MUST MATCH. | N54 | CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 541 | A MAXIMUM OF 12 MENTAL HEALTH VISITS CAN BE BILLED PER YEAR. AFTER 12 VISITS, CLAIMS MUST BE SUBMITTED TO IOWA PLAN. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 544 | MENTAL HEALTH SERVICES MUST BE BILLED TO MBC OF IOWA | | ... | 24 | CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN |
| 547 | THE SERVICE BILLED REPRESENTS FRAGMENTED AUDIOMETRY CHARGES. | N20 | SERVICE NOT PAYABLE WITH OTHER SERVICE RENDERED ON THE SAME DATE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 552 | THE THIRD SURGICAL PROCEDURE CODE IS NOT ON THE PROCEDURE FILE. | M67 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 557 | DUPLICATE J-CODE | | ... | 18 | EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO |
| 558 | OBSERVATION ROOM NOT PAYABLE FOR MENTAL HEALTH DIAGNOSIS. CLAIM MUST BE BILLED TO MENTAL HEALTH CONTRACTOR. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 109 | CLAIM/SERVICE NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 \| LAST MODIFIED: 01/29/2012... |
| 559 | THE FOURTH SURGICAL PROCEDURE CODE IS NOT ON FILE. | M67 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 560 | THE FIFTH SURGICAL PROCEDURE CODE IS NOT ON FILE. | M67 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 561 | THE SURGICAL PROCEDURE CODE IS NOT ON FILE. | M67 | MISSING/INCOMPLETE/INVALID OTHER PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 562 | THE FOURTH SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS AGE. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 563 | THE FIFTH SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS AGE. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 564 | THE SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS AGE. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 565 | THE FOURTH SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS SEX. | | ... | 7 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 566 | THE FIFTH SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS SEX. | | ... | 7 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 567 | THE SURGICAL PROCEDURE CODE IS NOT ALLOWED FOR RECIPIENTS SEX. | | ... | 7 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

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

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 657 | SERVICE NOT COVERED BY IOWA CARE. (OR) CLAIM IS NOT REFERRED BY BROADLAWNS PHYSICIANS OR HOSPITAL. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 204 | THIS SERVICE/EQUIPMENT/DRUG IS NOT COVERED UNDER THE PATIENT'S CURRENT BENEFIT PLA |
| 658 | SERVICE NOT COVERED BY IOWACARE - 300% OB GROUP POLICY | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 204 | THIS SERVICE/EQUIPMENT/DRUG IS NOT COVERED UNDER THE PATIENT'S CURRENT BENEFIT PLA |
| 659 | THE BILLED SERVICE IS NOT COVERED FOR THE MEMBER. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 256 | SERVICE NOT PAYABLE PER MANAGED CARE CONTRACT |
| 661 | THE CLAIM SUBMITTED REPRESENTS AN INTERIM BILL. HOWEVER, UNDER THE DRG REIMBURSEMENT SYSTEM ONLY DISCHARGE BILLS CAN BE SUBMITTED. | | ... | 135 | INTERIM BILLS CANNOT BE PROCESSED |
| 665 | FRAGMENTED CHARGES WERE BILLED FOR TOOTH EXTRACTION. ONLY 1 CHARGE CAN BE BILLED FOR EACH TOOTH EXTRACTION, INCLUDING REMOVAL & SUTURING. | N19 | PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 666 | A 3-MONTH SUPPLY IS THE MAXIMUM TIME PERIOD THAT CAN BE BILLED. THE QUANTITY BILLED EXCEEDS THE NUMBER ALLOWED FOR A 3-MONTH PERIOD. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 670 | THE COVERED DAYS BILLED WERE REDUCED TO THE NUMBER OF DAYS OF MEDICAID ELIGIBILITY. | | ... | 238 | CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE, THIS IS THE REDUCTION FOR THE INELIGIBLE PERIOD. (USE ONLY WITH GROUP CODE PR |
| 671 | THE RECIPIENT WAS NOT ELIGIBLE FOR MEDICAID FOR THE ENTIRE DATE SPAN BILLED. | | ... | 238 | CLAIM SPANS ELIGIBLE AND INELIGIBLE PERIODS OF COVERAGE, THIS IS THE REDUCTION FOR THE INELIGIBLE PERIOD. (USE ONLY WITH GROUP CODE PR |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 672 | THE 11TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 673 | THE 11TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 674 | THE 11TH DIAGNOSIS REQUIRES ATTACHMENTS | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 675 | THE 11TH DIAGNOSIS REQUIRES MEDICAL REVIEW | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 676 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 11TH DIAGNOSIS CODE | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 677 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 11TH DIAGNOSIS CODE | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 680 | THE RECIPIENT'S AGE ON THE ADMISSION DATE IS NOT WITHIN THE MINIMUM & MAXIMUM SPECIFIED FOR THE FIFTH DIAGNOSIS CODE BILLED. | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 682 | THE 12TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 683 | THE 12TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 684 | THE 12TH DIAGNOSIS REQUIRES ATTACHMENTS | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 685 | THE 12TH DIAGNOSIS REQUIRES MEDICAL REVIEW | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 686 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 12TH DIAGNOSIS CODE | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 687 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 12TH DIAGNOSIS CODE | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 688 | THE 13TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 689 | THE 13TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 690 | THE 13TH DIAGNOSIS REQUIRES ATTACHMENTS | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 691 | THE 13TH DIAGNOSIS REQUIRES MEDICAL REVIEW | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 692 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 13TH DIAGNOSIS CODE | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 693 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 13TH DIAGNOSIS CODE | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 696 | ATTENDING PROVIDER NOT ENROLLED WITH IOWA MEDICAID AS REQUIRED BY THE AFFORDABLE CARE ACT | N630 | REFERRAL NOT AUTHORIZED BY ATTENDING PHYSICIAN. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 697 | NUMBER OF TOTAL UNITS BILLED FOR ADMINISTRATION CODE (90460) SHOULD NOT BE MORE THAN VACCINES BILLED. | N430 | PROCEDURE CODE IS INCONSISTENT WITH THE UNITS BILLED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 698 | THE DISCHARGE HOUR IS MISSING OR INVALID. VALID VALUES ARE 00-23, AND 99. | N50 | MISSING/INCOMPLETE/INVALID DISCHARGE INFORMATION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 699 | INPATIENT AND OUTPATIENT CLAIM WITHIN 72 HRS OF EACH OTHER CANNOT BE BILLED SEPARATELY. | | ... | 60 | CHARGES FOR OUTPATIENT SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN A PERIOD OF TIME PRIOR TO OR AFTER INPATIENT SERVICES |
| 700 | POS EDIT - MISSING UNIT DOSE INDICATOR | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 701 | MISSING OR INVALID BIN. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 702 | MISSING OR INVALID VERSION NUMBER. CONTACT YOUR SOFTWARE VENDOR. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 703 | MISSING OR INVALID TRANSACTION CODE. CONTACT YOUR SOFTWARE VENDOR. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 704 | MISSING OR INVALID PROCESSOR CONTROL NUMBER. CONTACT YOUR SOFTWARE VENDOR. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 706 | MISSING OR INVALID GROUP NUMBER. RECIPIENT PLAN MUST HAVE 1906530. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 707 | POS EDIT - MISSING OTHER PAYER AMOUNT PAID | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 708 | MISSING OR INVALID PERSON CODE. CONTACT YOUR SOFTWARE VENDOR. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 709 | MISSING OR INVALID BIRTHDATE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 710 | MISSING OR INVALID SEX CODE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 711 | MISSING OR INVALID RELATIONSHIP CODE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 712 | MISSING OR INVALID CUSTOMER LOCATION CODE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 713 | MISSING OR INVALID OTHER COVERAGE CODE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 714 | MISSING OR INVALID ELIGIBILITY OVERRIDE CODE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 715 | POS EDIT - MISSING COMPOUND INGREDIENT QUANTITY | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 716 | POS EDIT - MISSING PRIOR AUTHORIZATION TYPE CODE | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 717 | MISSING OR INVALID NEW/REFILL INDICATOR. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 718 | POS EDIT - MISSING DISPENSING STATUS | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 719 | MISSING DAYS SUPPLY OR MAXIMUM DAYS SUPPLY EXCEEDED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 720 | MISSING OR INVALID COMPOUND CODE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 721 | POS EDIT - MISSING COMPOUND PRODUCT ID | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 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... |
| 729 | MISSING OR INVALID NUMBER OF REFILLS AUTHORIZED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 730 | MISSING OR INVALID PRIOR AUTHORIZATION NUMBER. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 732 | THE CLAIM REQUIRES DOCUMENTATION OF MEDICAL NECESSITY WHICH WAS NOT PROVIDED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 733 | MISSING OR INVALID PRESCRIPTION ORIGIN CODE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 734 | MISSING OR INVALID PRESCRIPTION DENIAL OVERRIDE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 735 | MISSING OR INVALID PRIMARY PRESCRIBER. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 736 | MISSING OR INVALID CLINIC ID. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 738 | MISSING OR INVALID BASIS OF COST. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 739 | MISSING OR INVALID DIAGNOSIS CODE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 741 | THIRD PARTY INSURANCE ON RECIPIENT FILE AND NOT ON CLAIM. CLAIM SET TO PAY. | N479 | MISSING EXPLANATION OF BENEFITS (COORDINATION OF BENEFITS OR MEDICARE SECONDARY PAYER). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 750 | CORRECT CODING EDIT - LAB PANELS | M15 | SEPARATELY BILLED SERVICES/TESTS HAVE BEEN BUNDLED AS THEY ARE CONSIDERED COMPONENTS OF THE SAME PROCEDURE. SEPARATE PAYMENT IS NOT ALLOWED. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 751 | NON-MATCHED GROUP NUMBER OR DATE OF SERVICE IS TOO OLD. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 753 | NON-MATCHED PERSON CODE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 755 | NON-MATCHED NDC PACKAGE SIZE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 757 | NON-MATCHED PA/MC NUMBER. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 758 | NON-MATCHED PRIMARY PRESCRIBER. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 759 | NON-MATCHED CLINIC ID | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 760 | DRUG NOT COVERED FOR RECIPIENT AGE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 761 | DRUG NOT COVERED FOR RECIPIENT GENDER. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 762 | PATIENT/CARD HOLDER ID NAME MISMATCH. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 763 | NDC NOT COVERED FOR THIS PATIENT. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 764 | CLAIM SUBMITTED DOES NOT MATCH PRIOR AUTHORIZATION. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 766 | RECIPIENT AGE EXCEEDS MAXIMUM AGE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 767 | THE RECIPIENT IS NOT ELIGIBLE FOR THE DATE OF SERVICE BILLED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 768 | FILLED AFTER COVERAGE EXPIRED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 769 | FILLED AFTER COVERAGE TERMINATED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 771 | PRESCRIBER IS NOT COVERED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 772 | PRIMARY PRESCRIBER IS NOT COVERED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 773 | REFILLS ARE NOT COVERED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 775 | PRIOR AUTHORIZATION IS REQUIRED FOR THE DRUG BILLED. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 778 | CLAIM DOES NOT MEET GUIDELINES FOR BILLING COMPOUNDS - PAPER CLAIM, NDC OF EACH INGREDIENT, ONE LEGEND PRODUCT, ETC. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 779 | THE PRESCRIPTION WAS REFILLED TOO SOON BASED ON THE DAYS SUPPLY AND THE QUANTITY SUBMITTED (COMBINING THIS AND PAST CLAIMS). | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 780 | DRUG-DIAGNOSIS MISMATCH. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 782 | DATED FILLED IS AFTER DATE CLAIM WAS RECEIVED. DATE OF SERVICE SHOULD BE REVIEWED FOR ACCURACY. | | ... | 110 | BILLING DATE PREDATES SERVICE DATE |
| 783 | INPATIENT READMISSION WITHIN 7 DAYS FOR SAME CONDITION PRIOR TO 7/1/15 OR WITHIN 30 DAYS FOR THE SAME CONDITION AFTER 7/1/15. | | ... | 249 | THIS CLAIM HAS BEEN IDENTIFIED AS A READMISSION. (USE ONLY WITH GROUP CODE CO |
| 784 | REVERSAL NOT PROCESSED. COULD NOT FIND ORIGINAL CLAIM BASED ON THE CRITERIA SUBMITTED. | N152 | MISSING/INCOMPLETE/INVALID REPLACEMENT CLAIM INFORMATION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 786 | SUBMIT MANUAL RESERVE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 788 | DUR REJECT FOR HIGH DOSAGE OR THERAPEUTIC DUPLICATION. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 790 | HOST SYSTEM UNAVAILABLE. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 799 | THIS CLAIM CANNOT BE PROCESSED ONLINE THROUGH THE POINT OF SALE (POS) SYSTEM - SUFFICIENT DOCUMENTATION WAS NOT PROVIDED FOR ADJUDICATION. | | ... | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 800 | PROVIDER IS NOT AN ELIGIBLE PROVIDER FOR THE DATE OF SERVICE BILLED ON THE CLAIM FORM. | N570 | MISSING/INCOMPLETE/INVALID CREDENTIALING DATA. | B7 | THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 801 | THE NATIONAL DRUG CODE BILLED IS NO LONGER VALID. THE NDC HAS BEEN DISCONTINUED FOR OVER ONE YEAR. | M119 | MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 802 | THE SUBMITTED DAYS SUPPLY IS MISSING, INVALID, OR GREATER THAN THE MAXIMUM QUANTITY ALLOWED( MAXIMUM DAYS SUPPLY). | N378 | MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 804 | INVALID PRESCRIBING PROVIDER NUMBER. IF RECIPIENT IS LOCKED-IN, THE WRONG LOCK-IN DOCTOR WAS SHOWN. | N31 | MISSING/INCOMPLETE/INVALID PRESCRIBING PROVIDER IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 805 | A MODIFIER IS REQUIRED WHEN BILLING THE PROFESSIONAL COMPONENT ONLY AND THE PLACE OF SERVICE IS HOSPITAL INPATIENT OR OUTPATIENT. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 806 | THE 14TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 807 | THE 14TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 808 | THE 14TH DIAGNOSIS REQUIRES ATTACHMENTS | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 809 | THE 14TH DIAGNOSIS REQUIRES MEDICAL REVIEW | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 810 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 14TH DIAGNOSIS CODE | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 811 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 14TH DIAGNOSIS CODE | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 814 | CROSS-OVER CLAIM CANNOT BE USED TO MEET SPENDDOWN. SUBMIT A MEDICAID CLAIM WITH THE MEDICARE PAYMENT AS THIRD-PARTY PAYMENT. | | ... | 178 | PATIENT HAS NOT MET THE REQUIRED SPEND DOWN REQUIREMENTS |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 816 | APC GROUPER ERROR-COMPOSITE E/M CONDITION NOT MET FOR OBSERVATION AND LINE ITEM DATE FOR CODE G0378 IS 1/1 | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 817 | APC GROUPER ERROR - OVERALL CLAIM DISPOSITION CAUSED DENIAL | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 818 | APC GROUPER ERROR - NON ALLOWED SERVICE FOR APC | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 819 | APC GROUPER ERROR - INVALID CODE APC | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 820 | APC GROUPER ERROR - PARTIAL HOSPITALIZATION | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 821 | APC GROUPER ERROR - NOT PROCESSED BY GROUPER | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 822 | APC GROUPER ERROR - NON IMPLANTABLE DME | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 823 | ERROR FROM APC GROUPER | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 824 | APC GROUPER ERROR 21 - MEDICAL VISIT ON THE SAME DAY AS A TYPE T OR S PROCEDURE WITHOUT MODIFIER 25 | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 825 | APC GROUPER ERROR 039 - MUTUALLY EXCLUSIVE PROCEDURE THAT WOULD BE ALLOWED BY NCCI IF APPROPRIATE MODIFIER WERE PRESENT | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 826 | APC GROUPER ERROR 040 - CODE2 OF A CODE PAIR THAT WOULD BE ALLOWED BY NCCI IF APPROPRIATE MODIFIER WERE PRESENT | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 827 | APC GROUPER ERROR 064 - AT SERVICE NOT PAYABLE OUTSIDE THE PARTIAL HOSPITALIZATION PROGRAM | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 828 | AN HOURLY HOME HEALTH REVENUE CODE WAS BILLED. HOURLY HOME HEALTH REVENUE CODES ARE ONLY PAYABLE FOR EPSDT OR APPROVED ETP SERVICES. | | ... | 6 | THE PROCEDURE/REVENUE CODE IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 832 | THE MAXIMUM DOLLAR AMOUNT ALLOWED PER YEAR HAS BEEN EXCEEDED. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 833 | THIS DENTAL SERVICE IS NOT COVERED FOR AN ADULT EFFECTIVE MARCH 1, 2002. | N129 | NOT ELIGIBLE DUE TO THE PATIENT'S AGE. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 841 | APC GROUPER ERROR - NO GROUPER DESCRIPTION - OFTEN HAPPENS WHEN THERE ARE NO PAYABLE LINES | M16 | ALERT: PLEASE SEE OUR WEB SITE, MAILINGS, OR BULLETINS FOR MORE DETAILS CONCERNING THIS POLICY/PROCEDURE/DECISION. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 842 | APC GROUPER ERROR 001 - INVALID DIAGNOSIS CODE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 843 | APC GROUPER ERROR 005 - E-DIAGNOSIS CODE CAN NOT BE USED AS PRINCIPAL DIAGNOSIS | MA63 | MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 844 | APC GROUPER ERROR 006 - INVALID PROCEDURE CODE | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 845 | APC GROUPER ERROR 017 - INAPPROPRIATE SPECIFICATION OF BILATERAL PROCEDURE | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 846 | APC GROUPER ERROR 042 - MULTIPLE MEDICAL VISITS ON SAME DAY WITH SAME REVENUE CODE WITHOUT CONDITION CODE G0 | M44 | MISSING/INCOMPLETE/INVALID CONDITION CODE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 847 | APC GROUPER ERROR 048 - REVENUE CENTER REQUIRES HCPCS | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 848 | CORRECT CODING EDIT - ADD ON | N122 | ADD-ON CODE CANNOT BE BILLED BY ITSELF. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 849 | CORRECT CODING EDIT - AGE/GENDER | M51 | MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 850 | CORRECT CODING EDIT - CCI RULE | | ... | 236 | THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 851 | CORRECT CODING EDIT - E/M | | ... | 236 | THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH... |
| 852 | CORRECT CODING EDIT - GLOBAL SURGERY | N525 | THESE SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN THE GLOBAL PERIOD OF ANOTHER SERVICE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 853 | CORRECT CODING EDIT - INCIDENTALS | N19 | PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 854 | CORRECT CODING EDIT - MEDICAL NECESSITY | N115 | THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,... | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 855 | CORRECT CODING EDIT - MULTIPLE SURGEONS | | ... | 236 | THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 856 | CORRECT CODING EDIT - MULTIPLE UNITS | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 857 | CORRECT CODING EDIT - NEW VISIT | | ... | 236 | THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH... |
| 858 | CORRECT CODING EDIT - OB | N525 | THESE SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN THE GLOBAL PERIOD OF ANOTHER SERVICE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 859 | CORRECT CODING EDIT - UNLISTED | N350 | MISSING/INCOMPLETE/INVALID DESCRIPTION OF SERVICE FOR A NOT OTHERWISE CLASSIFIED (NOC) CODE OR FOR AN UNLISTED/BY REPORT PROCEDURE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 860 | CORRECT CODING EDIT - DUPLICATE | N522 | DUPLICATE OF A CLAIM PROCESSED, OR TO BE PROCESSED, AS A CROSSOVER CLAIM. | 18 | EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO |
| 861 | THE 15TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 146 | DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED |
| 862 | THE 15TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 863 | THE 15TH DIAGNOSIS REQUIRES ATTACHMENTS | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 864 | THE 15TH DIAGNOSIS REQUIRES MEDICAL REVIEW | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 865 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 15TH DIAGNOSIS CODE | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 866 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 15TH DIAGNOSIS CODE | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 867 | THE 16TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 146 | DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED |
| 868 | THE 16TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 869 | THE 16TH DIAGNOSIS REQUIRES ATTACHMENTS | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 870 | THE 16TH DIAGNOSIS REQUIRES MEDICAL REVIEW | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 871 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 16TH DIAGNOSIS CODE | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 872 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 16TH DIAGNOSIS CODE | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 873 | THE 17TH DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 146 | DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED |
| 874 | THE 17TH DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 875 | THE 17TH DIAGNOSIS REQUIRES ATTACHMENTS | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 876 | THE 17TH DIAGNOSIS REQUIRES MEDICAL REVIEW | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 877 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE 17TH DIAGNOSIS CODE | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 878 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE 17TH DIAGNOSIS CODE | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 879 | THE DIAGNOSIS CODE IS NOT ON THE DIAGNOSIS FILE | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 146 | DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED |
| 880 | THE DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID/OR MEDICAL NECESSITY NOT ESTABLISHED WITH THE DIAGNOSIS BILLED. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 167 | THIS (THESE) DIAGNOSIS(ES) IS (ARE) NOT COVERED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 881 | THE DIAGNOSIS REQUIRES ATTACHMENTS | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 882 | THE DIAGNOSIS REQUIRES MEDICAL REVIEW | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 883 | THE RECIPIENT'S AGE IS NOT ALLOWED FOR THE DIAGNOSIS CODE | | ... | 9 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 884 | THE RECIPIENT'S SEX IS NOT ALLOWED FOR THE DIAGNOSIS CODE | N517 | RESUBMIT A NEW CLAIM WITH THE REQUESTED INFORMATION. | 10 | THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S GENDER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 885 | CORRECT CODING EDIT - MUE | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 50 | THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 886 | MEMBER IS NOT ELIGIBLE/ATTESTED FOR DATE OF SERVICE. | | ... | 177 | PATIENT HAS NOT MET THE REQUIRED ELIGIBILITY REQUIREMENTS |
| 887 | MCO PAYMENT REDUCTION APPLIED DUE TO IMD STAY. | | ... | 59 | PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES. (FOR EXAMPLE MULTIPLE SURGERY OR DIAGNOSTIC IMAGING, CONCURRENT ANESTHESIA.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PR... |
| 888 | CLAIM WAS SUBMITTED ELECTRONICALLY AND REQUIRES MEDICAL REVIEW. PLEASE RESUBMIT ON THE CORRECT FORM AND INCLUDE APPROPRIATE DOCUMENTATION. | N587 | POLICY BENEFITS HAVE BEEN EXHAUSTED. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 889 | INVALID WAIVER FOR RESPITE | N597 | ADJUSTED BASED ON A MEDICAL/DENTAL PROVIDER'S APPORTIONMENT OF CARE BETWEEN RELATED INJURIES AND OTHER UNRELATED MEDICAL/DENTAL CONDITIONS/INJURIES. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 890 | (Null) | | ... | 133 | THE DISPOSITION OF THIS SERVICE LINE IS PENDING FURTHER REVIEW. (USE ONLY WITH GROUP CODE OA). USAGE: USE OF THIS CODE REQUIRES A REVERSAL AND CORRECTION WHEN THE SERVICE LINE IS FINALIZED (USE ONLY IN LOOP 2110 CAS SEGMENT OF THE 835 OR LOOP 2430 OF ... |
| 891 | THE RECIPIENT HAS LIMITED ELIGIBILITY THROUGH PRESUMPTIVE ELIGIBILITY COVERAGE. THE SERVICE IS NOT AMBULATORY SERVICE AND IS NOT COVERED. | N30 | PATIENT INELIGIBLE FOR THIS SERVICE. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 892 | NO APG ASSIGNED BY APG GROUPER BASED ON DIAGNOSIS/PROCEDURE(S) SUBMITTED. MAY BE PACKAGED WITH OTHER SERVICES BILLED ON CLAIM. | M15 | SEPARATELY BILLED SERVICES/TESTS HAVE BEEN BUNDLED AS THEY ARE CONSIDERED COMPONENTS OF THE SAME PROCEDURE. SEPARATE PAYMENT IS NOT ALLOWED. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 893 | DRG GROUPER WAS NOT ABLE TO ASSIGN A DRG BASED ON THE DIAGNOSIS AND/ OR PROCEDURE CODING SUBMITTED. | | ... | A8 | UNGROUPABLE DRG |
| 894 | OPERATING ROOM PROCEDURE WAS NOT PROCESSED BY DRG GROUPER. VERIFY CODING SUBMITTED. | | ... | A8 | UNGROUPABLE DRG |
| 895 | DATE OF ONSET FOR ACUTE CARE CANNOT BE MORE THAN SIX MONTHS BEFORE SERVICE DATE. | MA100 | MISSING/INCOMPLETE/INVALID DATE OF CURRENT ILLNESS OR SYMPTOMS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 897 | THE DATE OF ONSET BILLED IS MISSING OR INVALID. | MA100 | MISSING/INCOMPLETE/INVALID DATE OF CURRENT ILLNESS OR SYMPTOMS. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 898 | LAST X-RAY DATE MORE THAN 365 DAYS BEFORE FIRST DATE OF SERVICE. | M1 | X-RAY NOT TAKEN WITHIN THE PAST 12 MONTHS OR NEAR ENOUGH TO THE START OF TREATMENT. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 899 | A DRG BASE RATE IS NOT AVAILABLE FOR THE SERVICE BILLED. | N208 | MISSING/INCOMPLETE/INVALID DRG CODE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 900 | CLAIM IS IN PROCESS. PLEASE DO NOT RESUBMIT THE CLAIM PRIOR TO PAYMENT OR DENIAL. | N185 | ALERT: DO NOT RESUBMIT THIS CLAIM/SERVICE. | 133 | THE DISPOSITION OF THIS SERVICE LINE IS PENDING FURTHER REVIEW. (USE ONLY WITH GROUP CODE OA). USAGE: USE OF THIS CODE REQUIRES A REVERSAL AND CORRECTION WHEN THE SERVICE LINE IS FINALIZED (USE ONLY IN LOOP 2110 CAS SEGMENT OF THE 835 OR LOOP 2430 OF ... |
| 901 | THE MEMBER WAS NOT,AT LEAST,AGE 21 WHEN COUNSELING WAS PROVIDED. | N129 | NOT ELIGIBLE DUE TO THE PATIENT'S AGE. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 902 | THE STERILIZATION CONSENT FORM IS NOT LEGIBLE OR IS COMPLETED INCORRECTLY. | N228 | INCOMPLETE/INVALID CONSENT FORM. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 903 | PRIOR AUTHORIZATION NUMBER IS INCORRECT. | M62 | MISSING/INCOMPLETE/INVALID TREATMENT AUTHORIZATION CODE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 904 | A 30-DAY WAITING PERIOD FOR STERILIZATION WAS NOT MET, 180 DAY MAXIMUM EXCEEDED OR 72 HR WAITING PERIOD FOR EMERGENCY STERILIZATION WAS NOT MET | | ... | 272 | COVERAGE/PROGRAM GUIDELINES WERE NOT MET |
| 905 | THE PERCENTAGE OF THE PROCEDURE THAT WAS COMPLETED MUST BE INCLUDED IN THE OPERATIVE REPORT. | N233 | INCOMPLETE/INVALID OPERATIVE NOTE/REPORT. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 906 | THE PHYSICIAN, MEMBER, COUNSELOR AND/OR INTERPRETER SIGNATURE/DATE ARE MISSING OR INVALID ON THE CONSENT FORM. | N228 | INCOMPLETE/INVALID CONSENT FORM. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 907 | ADD-ON CODES MUST ALWAYS BE BILLED IN CONJUNCTION WITH THE APPROPRIATE PRIMARY CODE. | N122 | ADD-ON CODE CANNOT BE BILLED BY ITSELF. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 908 | THE PROCEDURE/SURGERY WAS PERFORMED OUTSIDE OF AN OR FOR TREATMENT OF COMPLICATIONS OF ANOTHER SURGERY AND IS NOT SEPARATELY REIMBURSABLE. | N390 | THIS SERVICE/REPORT CANNOT BE BILLED SEPARATELY. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 909 | OFFICE VISIT NOTES/MEDICAL RECORD/THERAPY NOTES ARE REQUIRED TO REVIEW THIS SERVICE. PLEASE RESUBMIT CLAIM WITH DOCUMENTATION. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 910 | REQUIRED FIELDS ARE BLANK ON THE STERILIZATION CONSENT FORM. | N228 | INCOMPLETE/INVALID CONSENT FORM. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 911 | A VALID TOOTH NUMBER OR SURFACE IS REQUIRED FOR THIS PROCEDURE. | N75 | MISSING/INCOMPLETE/INVALID TOOTH SURFACE INFORMATION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 912 | THE ABORTION CERTIFICATE WAS NOT ATTACHED/MUST BE THE REVISED 07/11 VERSION. | N398 | MISSING ELECTIVE CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 913 | A PHYSICIAN SIGNED PROCEDURE/SURGICAL REPORT IS REQUIRED. | M29 | MISSING OPERATIVE NOTE/REPORT. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 914 | THE MEDICAL NECESSITY WAS NOT SHOWN FOR THE SERVICE AND/OR UNITS BILLED. | N163 | MEDICAL RECORD DOES NOT SUPPORT CODE BILLED PER THE CODE DEFINITION. | 50 | THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 915 | AN NCCI EDIT EXISTS FOR THE CODE COMBINATION BILLED. | | ... | 236 | THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPATIBLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER COMBINATION PROVIDED ON THE SAME DAY ACCORDING TO THE NATIONAL CORRECT CODING INITIATIVE OR WORKERS COMPENSATION STATE REGULATIONS/ FEE SCH... |
| 916 | THE DIAGNOSIS DOES NOT SUPPORT THE SERVICE BILLED. | | ... | 11 | THE DIAGNOSIS IS INCONSISTENT WITH THE PROCEDURE. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 917 | A DIAGNOSIS OR DOCUMENTATION INDICATING THE OUTCOME OF THE DELIVERY IS REQUIRED TO REVIEW THE CLAIM. | M76 | MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 918 | UNLISTED PROCEDURES CPT/HCPS CODES MUST BE CLEARLY IDENTIFIED IN BOX 19 ON CLAIM FORM. | N350 | MISSING/INCOMPLETE/INVALID DESCRIPTION OF SERVICE FOR A NOT OTHERWISE CLASSIFIED (NOC) CODE OR FOR AN UNLISTED/BY REPORT PROCEDURE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 919 | HYSTERECTOMY ACKNOWLEDGEMENT OR STERILIZATION CONSENT IS MISSING. | N3 | MISSING CONSENT FORM. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 920 | THE SERVICE/PROCEDURE BILLED IS NOT A MEDICAID BENEFIT. | N425 | STATUTORILY EXCLUDED SERVICE(S). | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 921 | STATUTORILY EXCLUDED SERVICE(S). | N425 | STATUTORILY EXCLUDED SERVICE(S). | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 922 | AMBULANCE SERVICE NEEDS TO BE BILLED TO MENTAL HEALTH CONTRACTOR, MAGELLAN. | N130 | CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE. | 109 | CLAIM/SERVICE NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM/SERVICE TO THE CORRECT PAYER/CONTRACTOR.STA RT: 01/01/1995 \| LAST MODIFIED: 01/29/2012... |
| 923 | BASED ON MEDICAL REVIEW, THE ASSISTANT AT SURGERY IS NOT MEDICALLY NECESSARY. | N115 | THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,... | 50 | THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 924 | THE CHARGE IS PART OF THE DRG OF THE FIRST HOSPITAL. | N47 | CLAIM CONFLICTS WITH ANOTHER INPATIENT STAY. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 925 | NO REASON WAS PROVIDED FOR AN AMBULANCE TRANSFER TO A DIFFERENT HOSPITAL. | | ... | 117 | TRANSPORTATION IS ONLY COVERED TO THE CLOSEST FACILITY THAT CAN PROVIDE THE NECESSARY CARE |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 926 | THE DOCUMENTATION SUBMITTED IS NOT LEGIBLE. | N205 | INFORMATION PROVIDED WAS ILLEGIBLE. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 927 | THIS CHARGE REPRESENTS FRAGMENTED/INCIDENTAL BILLING WITH OTHER CHARGES SUBMITTED. | N19 | PROCEDURE CODE INCIDENTAL TO PRIMARY PROCEDURE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 928 | DOCUMENTATION INDICATING FETAL STATUS AT THE TIME OF/OR PRIOR TO THE PROCEDURE IS REQUIRED TO REVIEW THIS CLAIM. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 929 | THIS SERVICE/PROCEDURE BILLED DOES NOT MEET MEDICARE LCD/NCD GUIDELINES. | N115 | THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,... | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 930 | SUPPORTING ULTRASOUND DOCUMENTATION IS REQUIRED IN ORDER TO EVALUATE THIS CLAIM. | M60 | MISSING CERTIFICATE OF MEDICAL NECESSITY. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 931 | THE INCORRECT MODIFIER HAS BEEN USED FOR ASSISTANT AT SURGERY/ASSISTANT SURGEON. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 932 | VISUAL FIELD ACUITY TEST, TAPED AND UNTAPED IS MISSING. | N178 | MISSING PRE-OPERATIVE IMAGES/VISUAL FIELD RESULTS. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 933 | UNITS OF SERVICE EXCEED MEDICALLY UNLIKELY EDIT/MAX UNITS. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 934 | SERVICE EXCEEDS FREQUENCY LIMITATIONS. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 935 | THE DATE SPAN OF THIS CLAIM OVERLAPS THE DATE SPAN OF THE PREVIOUS PAID CLAIM. | N300 | MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 936 | THERE IS NO DOCUMENTATION SHOWING MEMBER TRIALED EQUIPMENT AND DOCUMENTED RESULTS. | N223 | MISSING DOCUMENTATION OF BENEFIT TO THE PATIENT DURING INITIAL TREATMENT PERIOD. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 937 | THE CLAIM REQUIRES THE LENGTH OF THE EXTENSION SET. | M23 | MISSING INVOICE. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 938 | THERE IS A LIMIT OF ONE CONSULTATION PER PATIENT PER INDIVIDUAL PROVIDER PER 12 MONTHS FOR RELATED CONDITIONS. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 119 | BENEFIT MAXIMUM FOR THIS TIME PERIOD OR OCCURRENCE HAS BEEN REACHED |
| 939 | TWO SEPARATE PHYSICIANS HAVE BILLED FOR "INITIAL HOSPITAL CARE". ONLY ONE PHYSICIAN IS ALLOWED TO BILL THIS CODE PER HOSPITALIZATION. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 940 | THE BILLING INSTRUCTIONS ON THE DHS EXCEPTION LETTER WERE NOT FOLLOWED. | N54 | CLAIM INFORMATION IS INCONSISTENT WITH PRE-CERTIFIED/AUTHORIZED SERVICES. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 941 | A MODIFIER IS REQUIRED WHEN BILLING THIS SERVICE. | N519 | INVALID COMBINATION OF HCPCS MODIFIERS. | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 942 | CONCURRENT CARE WAS RENDERED. IT DID NOT MEET MEDICAID CRITERIA FOR PAYMENT. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 943 | PRIOR AUTHORIZATION FOR THE ITEM/SERVICE BILLED WAS NOT APPROVED. | M62 | MISSING/INCOMPLETE/INVALID TREATMENT AUTHORIZATION CODE. | 39 | SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 944 | THE MEDICAL NEED FOR THE AMBULANCE WAS NOT PROVIDED. | N115 | THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,... | 50 | THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 945 | THE MILES WERE REDUCED; THE TRIP WAS NOT TO THE NEAREST APPROPRIATE FACILITY. | | ... | 117 | TRANSPORTATION IS ONLY COVERED TO THE CLOSEST FACILITY THAT CAN PROVIDE THE NECESSARY CARE |
| 946 | AIR AMBULANCE NEED WAS NOT SHOWN. | N115 | THIS DECISION WAS BASED ON A LOCAL COVERAGE DETERMINATION (LCD). AN LCD PROVIDES A GUIDE TO ASSIST IN DETERMINING WHETHER A PARTICULAR ITEM OR SERVICE IS COVERED. A COPY OF THIS POLICY IS AVAILABLE AT WWW.CMS.GOV/MCD, OR IF YOU DO NOT HAVE WEB ACCESS,... | 150 | PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE |
| 947 | DOCUMENTATION IS NOT COMPLETE. | N705 | INCOMPLETE/INVALID DOCUMENTATION. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 948 | WARRANTY STATUS IS REQUIRED, PLEASE INCLUDE MAKE/MODEL/PURCHASE DATE. | N150 | MISSING/INCOMPLETE/INVALID MODEL NUMBER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 949 | FREQUENCY/DURATION/NUMBER OF HOURS PER VISIT FOR THE SERVICE IS REQUIRED | M53 | MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 950 | USE OF THE 22 MODIFIER IS NOT WARRANTED BASED ON REVIEW OF THE DOCUMENTATION PROVIDED. | N519 | INVALID COMBINATION OF HCPCS MODIFIERS. | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 951 | EXPERIMENTAL SERVICES/PROCEDURES ARE NOT COVERED. | N425 | STATUTORILY EXCLUDED SERVICE(S). | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 952 | DOCUMENTATION DESCRIBING INCREASED SERVICES IS REQUIRED FOR ADDITIONAL PAYMENT TO BE CONSIDERED. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 953 | MANUFACTURER'S INVOICE IS REQUIRED. | M23 | MISSING INVOICE. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 954 | THERE APPEARS TO BE A MORE SPECIFIC HCPCS/CPT/CDT PROCEDURE/REVENUE CODE THAT DESCRIBES THE ITEM OR SERVICE BILLED. | M81 | YOU ARE REQUIRED TO CODE TO THE HIGHEST LEVEL OF SPECIFICITY. | 189 | 'NOT OTHERWISE CLASSIFIED' OR 'UNLISTED' PROCEDURE CODE (CPT/HCPCS) WAS BILLED WHEN THERE IS A SPECIFIC PROCEDURE CODE FOR THIS PROCEDURE/SERVIC |
| 955 | OBSTETRICAL CARE MUST BE BILLED AS A GLOBAL FEE. | N525 | THESE SERVICES ARE NOT COVERED WHEN PERFORMED WITHIN THE GLOBAL PERIOD OF ANOTHER SERVICE. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 956 | PARAGRAPH 1 OR 2 NEEDS CROSSED OUT ON THE CONSENT FORM OR THE INCORRECT PARAGRAPH IS CROSSED OUT. | N28 | CONSENT FORM REQUIREMENTS NOT FULFILLED. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 957 | A SIGNATURE STAMP IS NOT VALID ON THE CONSENT FORM. | N399 | INCOMPLETE/INVALID ELECTIVE CONSENT FORM. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 958 | DOCUMENTATION INDICATING DATE OF SURGERY, DATE CPM USE BEGAN, AND/OR DATE OF DISCHARGE IS REQUIRED TO REVIEW THIS CLAIM. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 959 | THE SERVICES PROVIDED AND UNITS BILLED DO NOT MATCH. | N430 | PROCEDURE CODE IS INCONSISTENT WITH THE UNITS BILLED. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 960 | DATES OF SERVICES ARE OUTSIDE THE APPROVED PRIOR AUTHORIZATION DATE SPAN. | N351 | SERVICE DATE OUTSIDE OF THE APPROVED TREATMENT PLAN SERVICE DATES. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 961 | REQUIRED MEDICAL HISTORY AND PHYSICAL ARE MISSING. | N221 | MISSING ADMITTING HISTORY AND PHYSICAL REPORT. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 962 | DOCUMENTATION SHOWING DEGREE & DURATION OF SYMPTOMS & PRIOR ATTEMPTS AT CONSERVATIVE TREATMENT IS REQUIRED FOR REVIEW THIS CLAIM. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 963 | PROGRESS NOTES ARE MISSING. | N393 | MISSING PROGRESS NOTES/REPORT. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 964 | THIS ITEM IS NOT PAYABLE IN A NURSING FACILITY/SKILLED NURSING FACILITY. | M97 | NOT PAID TO PRACTITIONER WHEN PROVIDED TO PATIENT IN THIS PLACE OF SERVICE. PAYMENT INCLUDED IN THE REIMBURSEMENT ISSUED THE FACILITY. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |
| 965 | RESUBMIT CLAIM WITH PHOTOGRAPHS SUPPORTING MEDICAL NECESSITY (IF AVAILABLE). | N178 | MISSING PRE-OPERATIVE IMAGES/VISUAL FIELD RESULTS. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 966 | THE REFERENCE PROVIDER NUMBER IS MISSING OR INVALID. | N286 | MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 967 | THE PLACE OF SERVICE FIELD MUST REFLECT THE LOCATION WHERE SERVICE WAS PROVIDED. | M77 | MISSING/INCOMPLETE/INVALID/IN APPROPRIATE 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... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 968 | THE PLAN OF TREATMENT IS MISSING OR IS INVALID FOR SERVICES BILLED. | M135 | MISSING/INCOMPLETE/INVALID PLAN OF TREATMENT. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 969 | IOWA MEDICAID DOES NOT PROVIDE ADDITIONAL REIMBURSEMENT FOR THE 63 MODIFIER. | N519 | INVALID COMBINATION OF HCPCS MODIFIERS. | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 970 | DATE SPAN CONFLICTS WITH UNITS BILLED OR DATE SPAN REQUIRED WHEN BILLING THIS SERVICE. | N300 | MISSING/INCOMPLETE/INVALID OCCURRENCE SPAN DATE(S). | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 971 | AN INCORRECT CONDITION CODE WAS USED. | M44 | MISSING/INCOMPLETE/INVALID CONDITION CODE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 972 | INCOMPLETE/INVALID DOCUMENTATION/ORDERS/NOTES /SUMMARY/REPORT/CHART. | N705 | INCOMPLETE/INVALID DOCUMENTATION. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 973 | REPAIR OR REPLACEMENT OF DME IS NOT COVERED. | N171 | PAYMENT FOR REPAIR OR REPLACEMENT IS NOT COVERED OR HAS EXCEEDED THE PURCHASE PRICE. | 96 | NON-COVERED CHARGE(S). AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT.) USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 974 | THE PHYSICIAN ORDER IS MISSING. | N455 | MISSING PHYSICIAN ORDER. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 975 | SERVICE BILLED MUST BE CLEARLY IDENTIFIED ON INVOICE. | N354 | INCOMPLETE/INVALID INVOICE. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 976 | EQUIPMENT MUST BE PATIENT OWNED. | M124 | MISSING INDICATION OF WHETHER THE PATIENT OWNS THE EQUIPMENT THAT REQUIRES THE PART OR SUPPLY. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 977 | INCORRECT CONSENT FORM IS ATTACHED. | N228 | INCOMPLETE/INVALID CONSENT FORM. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 978 | ADDITIONAL INFORMATION IS REQUIRED. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 979 | INCORRECT MODIFIER FOR ITEM OR SERVICE BILLED. | N519 | INVALID COMBINATION OF HCPCS MODIFIERS. | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 980 | THE NDC IS NOT A REBATABLE NDC. | M119 | MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC). | 211 | NATIONAL DRUG CODES (NDC) NOT ELIGIBLE FOR REBATE, ARE NOT COVERED |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 981 | UNITS ON PRIOR AUTHORIZATION WERE EXCEEDED. | N362 | THE NUMBER OF DAYS OR UNITS OF SERVICE EXCEEDS OUR ACCEPTABLE MAXIMUM. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 982 | ITEMS BILLED ARE INCLUDED IN RENTAL FEE. | M86 | SERVICE DENIED BECAUSE PAYMENT ALREADY MADE FOR SAME/SIMILAR PROCEDURE WITHIN SET TIME FRAME. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 983 | DOCUMENTATION WAS NOT VALID FOR DATE(S) OF SERVICE/MEMBER BILLED. | N706 | MISSING DOCUMENTATION. | 250 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS THE INCORRECT ATTACHMENT/DOCUMENT. THE EXPECTED ATTACHMENT/DOCUMENT IS STILL MISSING. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMIT... |
| 984 | AN AMBULANCE RUN REPORT MUST BE SUBMITTED WITH THE CLAIM FORM. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 985 | DATE OF X-RAY IS INVALID. CHECK X-RAY DATE FOR VALIDITY UNDER IOWA MEDICAID POLICY. | N326 | MISSING/INCOMPLETE/INVALID LAST X-RAY DATE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |
| 986 | DIAGNOSTIC TESTING OR LABORATORY REPORTS ARE REQUIRED TO REVIEW THIS CLAIM. | N395 | MISSING LABORATORY REPORT. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 987 | DOCUMENTATION MUST INCLUDE DOSE/STRENGTH OF MEDICATION AND HEIGHT/WEIGHT AND BSA OF MEMBER. | M123 | MISSING/INCOMPLETE/INVALID NAME, STRENGTH, OR DOSAGE OF THE DRUG FURNISHED. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 988 | PHYSICIAN STATEMENT MUST BE SIGNED BY THE PHYSICIAN WHO PERFORMED THE PROCEDURE. A STAFF SIGNATURE IS NOT ACCEPTABLE. | MA81 | MISSING/INCOMPLETE/INVALID PROVIDER/SUPPLIER SIGNATURE. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 989 | REQUIRED ABORTION DOCUMENTATION IS MISSING. | N706 | MISSING DOCUMENTATION. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |
| 990 | THIS SERVICE IS AN EXACT DUPLICATE OF A PREVIOUSLY PAID CLAIM. | | ... | 18 | EXACT DUPLICATE CLAIM/SERVICE (USE ONLY WITH GROUP CODE OA EXCEPT WHERE STATE WORKERS' COMPENSATION REGULATIONS REQUIRES CO |
| 991 | THIS SERVICE HAS BEEN INCORRECTLY BILLED MULTIPLE TIMES ON ONE CLAIM FORM FOR THE SAME DATE OF SERVICE. | N390 | THIS SERVICE/REPORT CANNOT BE BILLED SEPARATELY. | 97 | THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT... |
| 992 | THERE IS A DISCREPANCY BETWEEN THE DATE OF BIRTH ON THE DOCUMENTATION AND DATE OF BIRTH LISTED IN OUR RECORDS. | N327 | MISSING/INCOMPLETE/INVALID OTHER INSURED BIRTH DATE. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
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| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 993 | THE FACILITY NAME IS MISSING. | N28 | CONSENT FORM REQUIREMENTS NOT FULFILLED. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 994 | THE OPERATIVE REPORT DOES NOT SUPPORT THE USE OF THE 62 MODIFIER OR MPFS INDICATES THAT CO-SURGEONS ARE NOT PAYABLE FOR THIS PROCEDURE. | N519 | INVALID COMBINATION OF HCPCS MODIFIERS. | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 995 | THE CLAIM MUST BE BILLED AS TECHNICAL COMPONENT ONLY - WITH MODIFIER TC. | | ... | 4 | THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED. USAGE: REFER TO THE 835 HEALTHCARE POLICY IDENTIFICATION SEGMENT (LOOP 2110 SERVICE PAYMENT INFORMATION REF), IF PRESENT |
| 996 | THE SERVICE BILLED DOES NOT MATCH THE ORDER. | N206 | THE SUPPORTING DOCUMENTATION DOES NOT MATCH THE INFORMATION SENT ON THE CLAIM. | 250 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS THE INCORRECT ATTACHMENT/DOCUMENT. THE EXPECTED ATTACHMENT/DOCUMENT IS STILL MISSING. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMIT... |
| 997 | MANUFACTURER'S PRICE INVOICE SUBMITTED IS NOT FOR THE ITEM BILLED. | N354 | INCOMPLETE/INVALID INVOICE. | 251 | THE ATTACHMENT/OTHER DOCUMENTATION THAT WAS RECEIVED WAS INCOMPLETE OR DEFICIENT. THE NECESSARY INFORMATION IS STILL NEEDED TO PROCESS THE CLAIM. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR RE... |
| 998 | THE BILL TYPE SUBMITTED IS INVALID OR INCORRECT FOR THE BILLING. CONSULT THE MEDICAID BILLING INSTRUCTIONS FOR THE CORRECT TYPE OF BILL. | MA30 | MISSING/INCOMPLETE/INVALID TYPE OF BILL. | 16 | CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S). USAGE: DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITT... |

# EOB Crosswalk

| PAPER | | | | ELECTRONIC | |
|---|---|---|---|---|---|
| EOB Code | EOB Description | Remark Code | Remark Description | Adjustment Reason | Adjustment Description |
| 999 | A PHYSICIAN ORDER SIGNED AND DATED WITHIN THE LAST YEAR OF SERVICE REQUEST IS REQUIRED. | N455 | MISSING PHYSICIAN ORDER. | 252 | AN ATTACHMENT/OTHER DOCUMENTATION IS REQUIRED TO ADJUDICATE THIS CLAIM/SERVICE. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE NCPDP REJECT REASON CODE, OR REMITTANCE ADVICE REMARK CODE THAT IS NOT AN ALERT) |