ID	Description
0001	MEDICARE PART A CLAIM FOR A VA/DOD PROV
0002	PAYMENT REDUCED DUE TO MEDICARE
0003	MEMBER HAS MEDICARE PRIMARY -REVIEW AND APPPLY MEDICARE POLICY
0174	INSURED ID NOT FOUND
0254	PROCEDURE CODE IS INVALID
0482	AUTHORIZATION ID NOT FOUND
0500	DIAGNOSIS CODE REQUIRED
0512	CLAIM TYPE IS INVALID
0513	PROV AGRMNT CD MUST BE P-PAR / N-NON PAR
0514	FROM AND THRU DATES ARE REQUIRED
0515	FROM DATE IS INVALID
0516	FROM DATE IS GREATER THAN CURRENT DATE
0517	THRU DATE IS INVALID
0518	THRU DATE IS GREATER THAN CURRENT DATE
0519	THRU DATE IS LESS THAN FROM DATE
0520	BILLING PROVIDER IS REQUIRED
0522	DCN IS REQUIRED
0524	DCN IS NOT UNIQUE
0528	DIAGNOSIS CODE NOT ON CLAIM
0529	AMOUNT BILLED IS REQUIRED
0530	CLAIM SERVICE DATES ARE REQUIRED
0531	POSSIBLE DUPLICATE CLAIM
0532	SERVICE DATES ARE NOT WITHIN CLAIM DATES
0555	CASE NOT FOUND FOR CLAIM
0557	CUSTOMER IS NOT ELIGIBLE
0578	CUSTOMER CLAIMS MUST BE REVIEWED
0592	NO BENEFITS FOUND FOR DATES OF SERVICE
0593	SEE MIS TO CONFIRM CONFIG
0609	INVALID PLACE OF SERVICE
0617	CLAIM HAS NO LINEITEMS
0628	CLAIM RELATED CAUSE IS INVALID
0629	AUTHORIZATION IS PENDING
0630	AUTHORIZATION IS DENIED
0631	REFERRAL ID IS REQUIRED
0632	REFERRAL NOT FOUND
0633	CLAIM PAST REFERRAL THROUGH DATE
0637	PROVIDER REVIEW REQUESTED
0639	FEE NOT FOUND FOR PROCEDURE CODE
0641	AUTHORIZATION ID IS REQUIRED
0656	CLAIM SUSPENDED/POSSIBLE OTHER INS
0660	CLAIM TYPE IS REQUIRED
0661	CLAIM RECEIVED AFTER NO# OF DAYS LIMIT
0663	INVALID FORMAT OF DCN
0809	CLAIM DOES NOT MATCH THE AUTH / SERVICE NOT AUTHORIZED
0815	VERIFY CUSTOMER COB INFORMATION
0826	DIAGNOSIS CODE #1 IS INVALID
0827	DIAGNOSIS CODE #2 IS INVALID
0828	DIAGNOSIS CODE #3 IS INVALID
0829	DIAGNOSIS CODE #4 IS INVALID
0862	AUTH PROV DOES NOT MATCH CLAIM PROV
0864	CLAIM DATES NOT WITHIN AUTH DATES
0866	REFERRAL INSURED NOT MATCH CLAIM INSURED
0867	REFERRAL PROV DOES NOT MATCH CLAIM PROV
0868	SERVICE NOT REFERRED
0869	MULTIPLE AUTHS MATCH CLAIM, MUST LOOKUP
0870	MULTIPLE REFRLS MATCH CLAIM, MUST LOOKUP
0871	AUTH INSURED DOES NOT MATCH CLM INSURED
0930	SERVICE LINE IS A DUP OF ANOTHER LINE
0931	TRAUMA DIAGNOSIS INDICATED FOR DIAG #1
0932	TRAUMA DIAGNOSIS INDICATED FOR DIAG #2
0933	TRAUMA DIAGNOSIS INDICATED FOR DIAG #3
0934	TRAUMA DIAGNOSIS INDICATED FOR DIAG #4
0942	THIS IS A CAPITATED SERVICE
0943	THIS IS A PARTIALLY CAPITATED SERVICE
1017	AUTHORIZATION IS CLOSED
1019	DIAGNOSIS 1 INDICATES POSS DENTAL CLAIM
1020	DIAG 2 - POSS WORKERS COMP/AUTO CLAIM
1021	DIAGNOSIS 2 INDICATES POSS DENTAL CLAIM
1022	DIAG 3 - POSS WORKERS COMP/AUTO CLAIM
1023	DIAGNOSIS 3 INDICATES POSS DENTAL CLAIM
1024	DIAG 4 - POSS WORKERS COMP/AUTO CLAIM
1025	DIAGNOSIS 4 INDICATES POSS DENTAL CLAIM
1026	MORE THAN 10 SMARTSUSPENSE ERRORS FOUND
1027	PROCEDURE NOT INDICATED FOR A MALE
1028	PROCEDURE NOT INDICATED FOR A FEMALE
1029	PROC IS CLASSIFIED AS A COSMETIC PROC
1030	PROCEDURE IS AN UNLISTED PROCEDURE
1031	PROC FOR NEWBORN PT (< 1 YEAR OLD)
1032	PROC FOR PEDIATRIC PT (1-17 YEARS OLD)
1033	PROC FOR MATERNITY PT (12-55 YEARS OLD)
1034	PROC FOR ADULT PT (OVER 14 YEARS OLD)
1035	PROC IS CLASSIFIED AS EXPERIMENTAL
1036	PROCEDURE CLASSIFIED AS AN OBSOLETE PROC
1037	PROC SUBMTD WITH MOD 26, BUT PROF RVU=0
1038	PROCEDURE REPLACED DUE TO AGE
1039	ASSISTANT SURGEON DENIED FOR THIS PROC
1040	PROC REPLACED WITH ESTABLISHED PT PROC
1041	PROC IS INCIDNTL PROC, PRIMARY PROC PRESENT

1042	PROC IS MUTUALLY EXCLUSIVE TO OTHER PROC
1043	PROCEDURE IS POST OPERATIVE
1044	PROCEDURE IS PRE OPERATIVE
1045	PROCEDURE REPLACED DUE TO REBUNDLING
1046	PROCEDURE REPLACED DUE TO SEX
1047	PROC REPLACED DUE TO INTENSITY OF SERV
1048	PROC IS MEDCL VISIT, PRIMARY PROC PRESENT
1049	PROC NOT EXPECTED WITH DIAGNOSIS CODE
1050	PROC INCLUDES UNILAT OR BILAT PERFORMANCE
1051	PROCEDURE IS A BILATERAL CODE
1052	PROC ALRDY DONE ALWBLE # TIMES IN PT LIFE
1053	PROC ALRDY DONE ALWBLE # TIMES IN DAY
1054	PROC - POSS WORKERS COMP/AUTO LIABILITY
1055	PROC INDICATES POSSIBLE DENTAL LIABILITY
1056	DIAG - POSS WORKERS COMP/AUTO LIABILITY
1057	DIAG INDICATES POSSIBLE DENTAL LIABILITY
1058	DIAG 1 - POSS WORKERS COMP/AUTO CLAIM
1066	INVALID TOOTH NUMBER
1067	INVALID TOOTH SURFACE 1
1068	INVALID PROSTHESIS CODE
1069	INVALID ORAL CAVITY
1079	PRESCRIBING PROVIDER ID IS INVALID
1082	DIAG CANNOT BE USED AS PRINCPL FOR DRG
1083	INVALID ADMISSION AGE FOR DRG PROCESSING
1084	INVALID PATIENT SEX FOR DRG PROCESSING
1085	INVALID DISCHRG STATUS FOR DRG PROCESS
1086	ILLOGICAL PRINCIPLE DIAG FOR DRG PROCESS
1087	INVALID PRINCIPLE DIAG FOR DRG PROCESS
1088	INVALID BIRTHWGHT IN GRAMS FOR DRG PROCESS
1089	CONFLICTING BIRTHWGHT/DIAG FOR DRG PROCESS
1090	NON-SPECFC BIRTHWGHT/DIAG FOR DRG PROCESS
1091	INVALID DISCHARGE AGE FOR DRG PROCESSING
1092	INVALID LENGTH OF STAY FOR DRG PROCESS
1093	INVALID FACILITY OR COUNTY FOR DRG PROCESS
1094	INVALID ADMIT SOURCE FOR DRG PROCESSING
1095	50 SERVICE LINE MAX EXCEEDED, SPLIT CLAIM
1102	E303 - PT SEX IS REQUIRED AND MUST HAVE A VALUE OF M OR F
1103	E304 - TABLE DATA INVALID - CONTACT GMIS - TABLE:
1104	E305 - SYSTEM LIMITS EXCEEDED - CONTACT GMIS - TABLE:
1105	E308 - INVALID PROCEDURE CODE
1106	E309 - DOB CANNOT BE GREATER THAN DOS
1107	E310 - FILE GCACPF UNAVAILABLE
1108	E311 - FILE CUSTACPF UNAVAILABLE
1109	E312 - NO PROCEDURE CODES ENTERED, CLAIM CANNOT BE AUDITED
1110	E313 - DOS REQUIRED FOR PROCEDURE
1111	E314 - CLIENT PROFILE RECORD NOT FOUND
1112	E315 - FILE CUSTMOD UNAVAILABLE
1113	E316 - FILE GCPLST UNAVAILABLE
1114	E317 - FILE CUSTPLST UNAVAILABLE
1115	E318 - ERROR WRITING INTEGRATED ERROR FILE (GCERR)
1116	E319 - FILE CUSTSS UNAVAILABLE
1117	E320 - DOS CANNOT BE A FUTURE DATE
1118	E321 - BIRTHDATE CANNOT BE A FUTURE DATE
1119	E324 - AGE CANNOT BE GREATER THAN 124 YEARS
1120	E426 - ACPF DATA INVALID - CONTACT GMIS
1121	E327 - ACCT NOT FOUND ON CLIENT OPTIONS FILE
1122	E430 - NUMBER OF PROCEDURES IS > 40
1123	E331 - GCPROF FILE ERROR - CONTACT YOUR SUPPORT REP
1124	E332 - ONLY ONE PROVIDER ALLOWED FOR CURRENT PROCEDURES
1125	E333 - PROVIDER IS REQUIRED FOR HISTORY PROCEDURES
1126	E334 - MODIFIER NOT VALID FOR THIS PROCEDURE
1127	E335 - INVALID MODIFIER/PROCEDURE CODE COMBINATION
1128	E336 - NO TRAILER RECORD FOR ACCOUNT
1129	E337 - NO TRANSACTION RECORDS FOR ACCOUNT
1130	E338 - RECORD COUNT MISMATCH
1131	E339 - PX COUNT MISMATCH
1132	E440 - CURRENT PROCEDURE LINES MUST HAVE SAME PROVIDER ID
1133	E341 - NO CUSTSS OPTION RECORDS FOUND FOR THIS ACCOUNT
1134	E442 - NOT USED
1135	E343 - DIAGNOSIS 1 MUST BE A VALID CODE
1136	E344 - DIAGNOSIS 2 MUST BE A VALID CODE
1137	E345 - DIAGNOSIS 3 MUST BE A VALID CODE
1138	E346 - DIAGNOSIS 4 MUST BE A VALID CODE
1139	E347 - DIAGNOSIS MUST BE A VALID CODE
1140	E448 - PROCEDURE LINE DIAGNOSIS MUST BE A VALID CODE
1141	E449 - NOT USED
1142	E350 - INVALID DATE (DATE OF BIRTH)
1143	E351 - INVALID DATE (DEFAULT DOS)
1144	E352 - INVALID DATE (PX-LEVEL DOS)
1145	E353 - INVALID AMOUNT CHARGED
1146	E354 - INVALID UCR
1147	E355 - USER ID REQUIRED
1148	E356 - RETURN PROGRAM REQUIRED
1149	E357 - SPACES NOT ALLOWED IN A NUMERIC FIELD
1150	E358 - ONLY 01 THROUGH 40 NUMBER PROCEDURES ALLOWED
1151	E359 - PROCEDURE STATUS MUST BE ZERO (0)
1152	E360 - CODE ORIGINATION MUST BE ZERO (0)
1153	E361 - CLAIM STATUS MUST BE THREE (3)
1154	E462 - CLAIM LEVEL PROVIDER OR PROCEDURE LINE PROVIDER REQUIRED

1155	E363 - ENTRY FROM MUST BE ONE (1)
1156	E364 - RESULTS DISPLAY MUST BE A, D, OR N
1157	E365 - CLIENT CLAIM NUMBER REQUIRED
1158	E366 - NUMBER PROCEDURES DOES NOT MATCH NUMBER SUBMITTED
1159	E367 - CODING SYSTEM MUST BE THREE (3)
1160	E368 - SOURCE PROGRAM MUST BE ONE (1)
1161	E369 - ENTRY MODE MUST BE A C
1162	E470 - NOT USED
1163	E371 - FILE GCPROF UNAVAILABLE
1164	E372 - FILE GCMCR UNAVAILABLE
1165	E373 - FILE GCME UNAVAILABLE
1166	E374 - FILE GCINC UNAVAILABLE
1167	E375 - FILE GCCPF UNAVAILABLE
1168	E376 - FILE GCLOG UNAVAILABLE
1169	E477 - HISTORY STATUS INDICATOR MUST HAVE GMIS VALID VALUE
1170	E378 - FILE GCLOG IS FULL
1171	E382 - FILE CUSTMCR UNAVAILABLE
1172	E383 - FILE CUSTME UNAVAILABLE
1173	E384 - FILE CUSTINC UNAVAILABLE
1174	E385 - FILE CUSTCPF UNAVAILABLE
1175	E386 - FILE GCIOS UNAVAILABLE
1176	E387 - FILE CUSTIOS UNAVAILABLE
1177	E388 - FILE GCDXPX UNAVAILABLE
1178	E389 - FILE CUSTDXPX UNAVAILABLE
1179	E390 - FILE CUSTICD UNAVAILABLE
1180	E391 - DATABASE VERSION NUMBER ERROR
1181	E392 - FILE GCMCE UNAVAILABLE
1182	E493 - FILE CUSTMCE UNAVAILABLE
1183	E395 - FILE CUSTPXDX UNAVAILABLE
1184	E396 - FILE MUE UNAVAILABLE
1185	E397 - FILE GCICD UNAVAILABLE
1186	E398 - FILE GCMOD UNAVAILABLE
1187	E399 - INVALID PROGRAM CALL
1216	DIAGNOSIS CODE #5 IS INVALID
1217	DIAGNOSIS CODE #6 IS INVALID
1218	DIAGNOSIS CODE #7 IS INVALID
1219	DIAGNOSIS CODE #8 IS INVALID
1220	DIAGNOSIS CODE #9 IS INVALID
1221	ADMIT DIAGNOSIS CODE IS INVALID
1276	RESPONSIBILITY OF PROVIDER
1334	CLAIM REACHED THRESHOLD OF
1348	PROCEDURE CODE IS NOT VALID FOR DATE
1350	CLAIM/AUTH TYPE IS NOT VALID FOR DATE
1352	DIAGNOSIS CODE #1 IS NOT VALID FOR DATE
1353	DIAGNOSIS CODE #2 IS NOT VALID FOR DATE
1354	DIAGNOSIS CODE #3 IS NOT VALID FOR DATE
1355	DIAGNOSIS CODE #4 IS NOT VALID FOR DATE
1356	DIAGNOSIS CODE #5 IS NOT VALID FOR DATE
1357	DIAGNOSIS CODE #6 IS NOT VALID FOR DATE
1358	DIAGNOSIS CODE #7 IS NOT VALID FOR DATE
1359	DIAGNOSIS CODE #8 IS NOT VALID FOR DATE
1360	DIAGNOSIS CODE #9 IS NOT VALID FOR DATE
1361	ADMIT DIAGNOSIS IS NOT VALID FOR DATE
1376	SERVICE IS INCLUDED IN CASE RATE
1377	UNITS AUTHORIZED LESS THAN UNITS BILLED
1378	PLEASE REVIEW AUTHORIZATION FOR ADDITIONAL INFORMATION
1379	RBRVS FEE SCHEDULE VALUES CONTAINS ZEROS-REQ MANUAL PRICING
1382	SUSPEND FOR FINANCIAL REVIEW
1384	MIN/MAX PRV CONTRACT FEE RULE USED
1385	DUPLICATE CLAIM
1386	MULTIPLE DUPLICATE CLAIMS
1387	MULTI DUP CLMS FOR SRV LINE
1388	CALC AMOUNT IS > TOTAL BILLED AMT
1389	SERVICE PARTIALLY INCLUDED IN CASE RATE, HLF FEE SCHEDULE ID
1390	CASE RATE COULD NOT BE PROCESSED FOR FEE SCHEDULE BECAUSE NO ROOM AND BOARD REVENUE CODE FOUND
1391	SERVICE INCLUDED IN INPATIENT CASE RATE
1392	MEDICARE UNASSIGNED CLAIM
1393	OTHER INSURANCE DENIED THIS SERVICE/CLAIM
1394	MEDICARE EXCLUSION APPLIED
1398	STATUS CAN'T CHG,ADJ/VD/REV ISSUED ORIG CLM
1399	PROV RETRN NOT SUFF TO CVR SELECT CLAIM(S)
1401	UCR FEE SCHEDULE VALUES CONTAIN ZEROS
1405	QA - PERCENT OF CLAIMS
1406	QA - CLAIMS NTH RECORD
1407	QA - CLAIM BILLED AMT
1408	QA - CLAIM ALW/PD AMT
1409	QA - CLAIM TYPE
1416	PROV MUST HAVE TIER SELECTOR CONTRCT RULE
1500	INELIGIBLE PROVIDER-CONTACT PROVIDER SVCS
1501	NOT COVERED PROVIDER
1502	PROVIDER UNDER INVESTIGATION
1503	PROVIDER UNDER REVIEW BY FRAUD/ABUSE UNIT
1504	PROVIDER DEBARRED FROM THE PLAN
1505	MEMBER HAS OHC PRIMARY- REVIEW AND APPLY OHC POLICY
1506	VERIFY BENEFIT AND TIER COB INFORMATION
1508	POSSIBLE DUPLICATE PAID CLAIM FOR MULT SERVICES/SAME DAY
1509	BENEFITS EXHAUSTED - PAID TO BENEFIT LIMIT
1513	SUSPENDED FOR ESRD REVIEW

1514	PRE-CERTIFICATION REQUIRED - PENALTY APPLIED
1517	CLAIM RECVD AFTER FILING LIMIT CUTOFF DATE
1519	SEE MIS TO CONFIRM CONFIG
1520	PPO BENEFITS HAVE BEEN APPLIED
1521	SPECIAL DOD PRICING APPLIES
1522	DRG LMTNG APPLIED;PT NOT RESP FOR DIFF
1523	MEDICARE B LMT APPLD;PT NOT RESP FOR DIFF
1524	MEDICARE 115% LMT;MBR NOT RESP FOR DIFF
1525	DRG PROCESSING HAS BEEN APPLIED
1526	PT MAY BE RESP-DIFF OF AMT CHRG & AMT PD
1527	AUTH NOT TIMELY - PENALTY APPLIED
1600	GROUPER RETURN CODE 1 IS INVALID
1601	APG PACKING FILE I/O ERROR
1602	APG CONSOLIDATION FILE I/O ERROR
1603	DIAG/PROCEDURE PARAMETERS INVALID
1604	GROUPER RETURN CODE 2 IS INVALID
1605	HSS GROUPER SYSTEM WAS NOT FOUND
1606	HSS PRICING SYSTEM WAS NOT FOUND
1607	NO HOSPITAL RATE
1608	NO DRG RATE
1609	INVALID TYPE
1610	NEW YORK REIMBURSMENT NEGATIVE
1611	NO DRG WEIGHTS/RATES
1612	ATTEMPTED DIVIDE BY ZERO
1613	HHPO, UNKNOWN PAY STRATEGY
1614	HHPO, NOT PRICING POSSIBLE FOR THIS DRG
1615	HHPO, NO PRICING POSS FOR NEONATAL TRNSFR
1616	HHPO OUTPT, UNKNOWN OUTPT PRICING STRATEGY
1617	NORTH CAROLINA MEDICAID, ADMIT DATE EQUALS DISCHARGE DATE
1618	MULTI-PRICER, INVALID PAYER TYPE
1619	MULTI-PRICER, INVALID TIER START DAYS
1620	INVALID FUNCTION CODE
1621	INVALID PRICER TYPE
1622	INVALID PATIENT TYPE
1623	INVALID FUNCTION FOR THIS PATIENT TYPE
1624	INVALID FROM/THROUGH DATE RELATIONSHIP
1625	INVALID DIAGNOSIS OR PROC CODE COUNT
1626	PRICER RETURN CODE 1 IS INVALID
1627	HOSPITAL RATE CALCULATOR FILE I/O ERROR
1628	DRG WEIGHT RATE FILE I/O ERROR
1629	PRICER RETURN CODE 2 IS INVALID
1630	PROVIDER IS MISSING MEDICARE NUMBER
1631	E301 - CLAIM DIAGNOSIS INVALID BASED ON ICD-9 EXPIRATION DATE
1632	E302 - CLAIM DIAGNOSIS INVALID BASED ON ICD-10-CM EFF DATE
1633	E306 - NOT USING
1634	E307 - DO NOT USE
1635	E321 - BIRTHDATE CANNOT BE A FUTURE DATE
1636	E323 - NOT USING
1637	E325 - NOT USING
1638	E328 - NOT USING
1639	E329 - NOT USING
1640	E379 - DIAGNOSIS INVALID BASED ON ICD-9 EXPIRATION DATE
1641	E380 - DIAGNOSIS INVALID BASED ON ICD-10-CM EFFECTIVE DATE
1642	E381 - FILE GCXWALK UNAVAILABLE
1643	E394 - FILE GCPCDX UNAVAILABLE
1644	AMT REDUCED DUE TO NONCVRD SERV/CONSTRNT
1645	OTHER PROC CODE IS REQ / BUNDLED SERVICE
1646	OTHER PROCEDURE CODE IS INVALID
1647	ADJUSTMENT HAS CREATED A CLAIM OVERPAYMENT
1648	MANUAL RE-PRICING REQUIRED
1649	PAY AMT THRSHLD EXCEED;PROV FLAGGED-REVIEW
1650	CLAIMCHECK DATA/DATABASE/FILE OPEN ERROR - CLAIM NOT AUDITED
1651	PROV STATE MISSING - CLD NOT SEND TO REPRICE
1652	BENEFIT MAXIMUM AMOUNT EXCEEDED
1653	CLAIM REVIEW - DIAGNOSIS TO PROCEDURE DENIAL
1654	CLAIM REVIEW - DIAGNOSIS TO PROCEDURE FLAG
1655	CLAIM REVIEW - DX TO PROC MONITOR
1656	CLAIM REVIEW - NEW VISIT FREQUENCY
1657	CLAIM REVIEW - INTENSITY OF SRV REPLACEMENT
1658	CLAIM REVIEW - INTENSITY OF SERVICE SUSPEND
1659	CLAIM REVIEW - INTENSITY OF SERVICE MONITOR
1660	CLAIM REVIEW - MULTIPLE COMPONENT BILLING SUSPEND
1661	CLAIM REVIEW-MULTI COMPONENT BILLING MONITOR
1662	CLAIM REVIEW - MULTIPLE COMPONENT BILLING SUSPEND
1663	CLAIM REVIEW-MULTI COMPONENT BILLING MONITOR
1664	MULTIPLE VALUE OPTION PROVIDERS FOUND
1665	MULTIPLE REPRICING PROVIDERS FOUND
1666	MULTIPLE MEDSOLUTIONS PROVIDERS FOUND
1667	MULTIPLE MEDICARE B LIMITING PROVIDERS FOUND
1668	CLM PAID TO MBR. MBR RESPONS TO PAY PROV
1669	SUBMIT CLAIM DIRECTLY TO
1670	MULTIPLE TRAVEL NETWORK PROVIDERS FOUND
1671	AUTHORIZATION REQUIRED FROM
1672	ONLY PARTIAL DATES COVERED ON AUTH
1673	PROCEDURE CODE REQUIRES A MODIFIER
1674	CLAIM UNIT TYPE NOT MATCH AUTH UNIT TYPE
1675	MODIFIER IS INVALID
1676	PROC NOT SUPPORT TECH COMPONENT MODF
1677	PROC NOT SUPPORT PROF COMP MODIFIER

1678	PROC NOT SUPPORT MULTIPLE PROC MODF
1679	PROC NOT SUPPORT BILATERAL PROC MODF
1680	PROC NOT SUPPORT ASST SURGERY MODF
1681	PROC NOT SUPPORT CO-SURGERY MODIFIER
1682	PROC IS NOT VALID FOR PATIENT GENDER
1683	PROCEDURE IS NOT VALID FOR PATIENT AGE
1684	MULTIPLE PROCPAY PERCENTAGE APPLIED
1685	AUTO-RECOVERY OF SUBROGATION REQUIRED
1686	CLM PAYMENT APPLIED TO ONGOING SUBRO CASE
1687	CLAIM PART OF PENDING SUBROGATION CASE
1688	POSSIBLE SUBROGATION EXISTS, INFO REQUIRED
1690	RESUBMIT CLM W/ MEDICARE/OHC REMIT ADVICE
1691	VA CLAIM - NO MEMBER LIABILITY ASSESSED
1692	MANUAL OVERRIDE
1693	NPI SELF CHECK DIGIT IS INVALID
1694	NOT ACCEPTED AFTER 5/23/07 W/OUT VALID NPI
1695	CLAIM SUSPENDED DUE TO W9 PROVIDER VALIDATION
1696	PRIVATE ROOM CHRG-VALUE CODE/AMT INVALID
1697	CODE IS INVALID / NOT VALID FOR SERV DATE
1698	CODE IS VALID FOR SERV DATE,NOT ELIG ASC
1699	INVALID GROUPER TYPE
1700	INVALID FROM/THRU DATE RELATIONSHIP
1701	INVALID PRINCIPAL DIAGNOSIS CODE
1702	DX/OP FILE I/O ERROR
1703	EDIT RULE FILE I/O ERROR
1704	EDIT RETURN CODE IS INVALID
1705	INVALID EDITOR OPERATION CODE
1706	NUMBER OF PROCEDURES < 1
1707	OPCODE = 4 OR 5 AND MAXCCIERR < 1
1708	UNSUPPORTED BILL TYPE
1709	NUMBER OF DIAGNOSES < 1
1710	NO MATCH ACE OVRRIDE ID FOUND IN ACERLE FILE
1711	ERROR OPENING ACE CODE FILE
1712	ERROR OPENING CCI PAIRS FILE
1713	ERROR OPENING OCE/CCI PAIRS FILE
1714	ERROR OPENING ACERULE FILE
1715	NO APG RATE RECORD
1716	PRICER TYPE NOT LICENSED
1717	CASE NOT PRICED
1718	ER VISIT/NONEMERGNT DIAG, PAY REDUCED
1719	INTEREST AND/OR PENALTY INCLUDED
1720	NONE OF DX ON LINE MEET MED NEC FOR PROC
1721	DX ON LINE MEET MED NEC FOR PROC,H/E NOT PRIM
1722	PRIMRY DX ON LINE NOT MEET MED NEC FOR PROC
1723	SEC DX ON LINE MISS/NOT MEET MED NEC FOR PROC
1724	TERTRY DX ON LINE MISS/NOT MEET MED NEC FOR PROC
1725	REQ MOD IS NEEDED TO MEET MED NECFOR PROC
1726	PTS AGE NOT MEET POLICY FOR PROC
1727	DX NOT MEET CODE TO CODE DX GUIDELNS FOR PROC
1728	MOD NEEDED WHEN CODE-TO-CODE RELATION W/ PROC
1729	NEED ADDL PROC TO MEET GUIDE WHEN BILL PROC
1730	PER LCD/NCD, FREQ FOR PROC HAS BEEN EXCEEDED
1731	POS DOES NOT MEET GUIDE FOR PROC
1732	PER LCD/NCD,PTS GENDER DNM GUIDE FOR PROC
1733	PROC REQ MOD WHEN BILLED IN THIS POS
1734	ACCT ID CANNOT BE LOCATED IN THE ACCTS LIST
1735	SURG PROC CXWLK TO ANESTH PROC FOR CLAIM EDIT
1736	PROC BILLED NOT LISTED AS ANESTH/NURSE ANESTH
1737	ONLY ALW ANESTH CODE W/HIGHEST VALUE PER OR SESS
1738	BEGIN/END DOS INVID/MISS OR BEGIN DOS>PT DOB
1739	REVIEW PROC FOR POSS BILAT REDUC/PAY ADJ/25%
1740	THE PLACE OR SERVICE IS MISSING OR INVALID
1741	UNABLE TO CXWALK SURG CODE TO ANESTH CODE
1742	PROC CODE NOT TYPICAL FOR AGE OF PT
1743	BEG/END DOS INVLD/MISS OR BEG DOS > PTS DOB
1744	PROCEDURE CODE HAS BEEN DELETED
1745	PROC CODE IS TYPICALLY CONSIDERED COSMETIC
1746	PROC CODE IS INVALID, MISSING OR DISABLED
1747	PROC NOT TYPICALLY FOR PT WHOSE GENDER IS M
1748	USE OF MODIFIER 59 MAY REQ SUPPORTING DOCS
1749	THIS LINE IS POSSIBLE DUPLICATE
1750	PATIENTS DOB IS MISSING/INVALID OR AFTER DOS
1751	DISCREPANCY DETECTED BTWN NO OF UNITS AND DOS
1752	CLAIM IS POSSIBLE DUPLICATE
1753	PROC W/N GLBL PERIOD OF 30 DAYS OF PREV PROC
1754	PROC W/N GLBL PERIOD OF 90 DAYS OF PREV PROC
1755	DX CODE IS NOT TYPICAL FOR AGE OF PATIENT
1756	NONE OF DX ON LINE ARE FREQ ASSOC DX FOR PROC
1757	DIAGNOSIS CODE IS INVALID OR INACTIVE
1758	THERE IS NO PRIMARY DX FOR THIS PROCEDURE
1759	REPLACE SURG CPT W/ANESTH CODE
1760	DX IS NON-SPECIFIC DX; REQUIRES 4TH/5TH DIGIT
1761	MODIFIER COMBO CANNOT BE BILLED ON SAME LINE
1762	MODIFIER IS INVALID OR DISABLED
1763	PROC CONSIDERED INVESTIGATIONAL/EXPERIMENTAL
1764	DIAGNOSIS IS NOT TYPICAL FOR GENDER
1765	PROC REQ MOD 26 IF BILL PRO IN PLACE OF SERV 22
1766	MEDCR RESTRICT FOR ASSTS AT SURGERY APPLIES
1767	PER MEDCR, USUAL PAY ADJST FOR BILAT PROC N/A

1768	PAY FOR PROC ALWYS BUNDLED
1769	PAY BUNDLE INTO OTH SERV BILL SM DAY/SM PROV
1770	BILLING FOR CO-SURGNS NOT PERMITTED FOR PROC
1771	PROC REQ DOC REV TO ESTB MED NEC OF SRG ASST
1772	PROC REQ DOC REVW TO ESTB MED NEC OF 2 SURGNS
1773	PROC REQ DOC TO ESTABL MED NEC OF SURG TEAM
1774	PROC W/ DAILY FREQ OF 1 EXCEEDED FOR DOS
1775	PROC W/IN GLOBAL PRD OF HX PROC FOR SAME COND
1776	ASST SURGEON MOD IS NOT APPROPRIATE FOR PROC
1777	PROC BUNDLED WHEN OTHR BILLED SM DAY/SM PRV
1778	PROC DOES NOT TYP REQ PERFORM BY PHYS IN POS
1779	PROCEDURE CODE IS NOT COVERED BY MEDICARE
1780	PROC CODE IS NOT VALID FOR MEDICARE PURPOSES
1781	USE OF MODIFIER IS NOT TYPICAL FOR PROC CODE
1782	REVW PROC FOR POSS MULTI REDUCTION/PAY ADJST
1783	PROC IS PT SRV, NO PAY IS MADE DUE TO POS
1784	TEAM SURGERY IS NOT PERMITTED FOR PROCEDURE
1785	HX PROC CODE HAS A UNBUNDLED RELATIONSHIP
1786	PROC WAS BILLED ON SAME DAY AS E/M CODE
1787	DX DESCRIBE EXTRNL CAUSE OR REQ ICD FOR DISEASE
1788	PT SAW PRV W/IN LAST 3 YRS;ESTB E/M CODE S/B PD
1789	PATIENT ID IS MISSING
1790	MOD 26 NOT APPR;PROC IS 100% PRO OR TECH
1791	PROCEDURE CODE WAS UNBUNDLED
1792	PROC NOT TYP PERFORMED BY A PHYSICIAN AT POS
1793	PROC REDUC APPLD FOR SA/CO-SURG/TEAM SURGERY
1794	PREOP SERV 1 DAY BFRE/SM DAY AS HX SURG PROC
1795	PROC NOT ALLOWED AS PART OF GLOBAL PCKG
1796	PROVIDER ID IS MISSING
1797	GENDER FOR PT IS EITHER MISSING OR INVALID
1798	>1 PROC ON SAME DOB W/SA MOD; ONLY 1 SA /PROC
1799	PROC CODE TYPICALLY REQUIRES NOT SURG ASST
1800	DX COULD INVOLVE TPL AND/OR SUBRO OF BENEFITS
1801	PROC CODE IS AN UNLISTED PROC OR SERVICE
1802	RETAIN PROC-TRNSFR RELATION ON OTHER CLAIM
1803	REMOVE HX PROC-TRNSFR RELATION ON OTHER CLAIM
1804	RETAIN HX PROC-TX RELATIONSHIP ON OTHER CLAIM
1805	DENY PROC - TRANSFER RELATIONSHIP IS 27465
1806	ADD PROCEDURE CODE TO THE CURRENT CLAIM
1807	APC PROCESSING HAS BEEN APPLIED
1808	INVALID TOOTH SURFACE 2
1809	INVALID TOOTH SURFACE 3
1810	INVALID TOOTH SURFACE 4
1811	INVALID TOOTH SURFACE 5
1812	OTHER PROC CODE IS NOT VALID FOR DATE
1813	INVALID AGE; NOT IN RANGE 0 - 124
1814	MEMBER GENDER IS REQUIRED/INVALID
1815	INVALID DISCHARGE DISPOSITION/PATIENT STATUS
1816	INVALID BIRTHWEIGHT
1817	ALL O.R. PROCEDURES ARE UNSPECIFIC
1818	TWO OR MORE DIFF JOINT PROCS ARE PRESENT
1819	AGE OR GENDER AND DIAGNOSIS ARE INCONSISTENT
1820	MEDICARE MAY BE SECONDARY PAYER
1821	INVALID PCS/PROCEDURE CODE FOR DRG/APC PROCESSING
1822	INVALID PATIENT SEX FOR PROCEDURE CODE
1823	MEDICARE MAY BE SECONDARY PAYER
1824	NON-COVERED FOR REASON OTHER THAN STATUTE
1825	QUESTIONABLE COVERED SERVICE
1826	SEPARATE PAYMENT FOR SERVICES IS NOT PROVIDED BY MEDICARE
1827	SITE OF SERVICE NOT INCLUDED IN OPPS
1828	UNITS EXCEED MAXIMUM (MUE)
1829	MULTIPLE BILATERAL PROC WITHOUT MOD 50
1830	INAPPROPRIATE SPECIFICATION OF BILAT PROC
1831	INPATIENT PROCEDURE
1832	MUT EXCLUSIVE PROC IS NOT ALLOWED BY NCCI
1833	CODE 2 OF CODE PAIR NOT ALLOWED BY NCCI
1834	VISIT SAME DAY AS TYPE T OR S W/O MOD 25
1835	INVALID DATE OF SERVICE
1836	TERMINATED BILATERAL PROCEDURE
1837	INCONSIST INPLANTED DEVICE & ASSOC PRC
1838	MUTUALLY EXCL PROC-ALLOWED WITH NCCI MOD
1839	CODE 2 OF CODE PAIR-ALLOWED WITH NCCI MOD
1840	INVALID/MISSING REVENUE CODE
1841	MULTI MED VISITS SAME DAY W/SAME REV CODE
1842	TRANSFUSE/BLOOD PROD W/O SPEC OF BLOOD PROD
1843	OBS REV CODE ON LINE W/ NON OBS HCPCS CODE
1844	INPATIENT SEPARATE PROCEDURES NOT PAID
1845	SERVICE IS NOT SEPARATELY PAYABLE
1846	REVENUE CENTER REQUIRES HCPCS CODE
1847	SERVICE ON SAME DAY AS INPATIENT PROCEDURE
1848	NON-COVERED BASED ON STATUTORY EXCLUSION
1849	MULTIPLE OBSERVATIONS OVERLAP IN TIME
1850	OBSERVATION DOES NOT MEET MINIMUM HOURS
1851	G0378 & G0379 ONLY ALLWD W/ BILL TYPE13X
1852	MULTIPLE CODES FOR THE SAME SERVICE
1853	NON-REPORTABLE FOR SITE OF SERVICE
1854	E/M COND NOT MET. G0244 NOT 12/31 OR 1/1
1855	E/M CONDITION NOT MET FOR OBSERVATION AND LINE ITEM DATE FOR CODE G0378 IS 1/1 (EASYGROUP)
1856	G0379 ONLY ALLOWED WITH G0378

1857	CLINIC TRIAL REQ V707 AS OTH THAN PRIM DX
1858	USE OF MOD CA W/ > 1 PROC NOT ALLOW
1859	SERVICE CAN ONLY BE BILLED TO THE DMERC
1860	CODE NOT RECOGNIZED BY OPPS
1861	OT CODE ONLY BILLED ON PARTIAL HOSP CLAIMS
1862	AT SERV NOT PAY OUTSIDE PARTIAL HOSP PROG
1863	REVENUE CODE NOT RECOGNIZED BY MEDICARE
1864	CODE REQUIRES MANUAL PRICING
1865	SERVICE PROVIDED PRIOR TO FDA APPROVAL
1866	SERV PROV PRIOR TO DATE OF NCD APPROVAL
1867	SERVICE PROVIDED OUTSIDE APPROVAL PERIOD
1868	CA MODIFIER REQUIRES PATIENT DISCHARGE INDICATING EXPIRED OR TRANSFERRED
1869	CLAIM LACKS REQUIRED DEVICE CODE
1870	SERVICE NOT BILLABLE TO THE FI/MAC
1871	INCORRECT BILLING OF BLOOD AND BLOOD PRODUCTS
1872	UNITS > 1 FOR BILAT PROC BILLD W/ MOD 50
1873	INCORRECT BILLING OF MODIFIER FB OR FC
1874	TRMA RESP CC CD W/O REV CD 068X & CPT99291
1875	CLAIMS LACKS ALLOWED PROCEDURE CODE
1876	CLAIMS LACKS REQUIRED RADIOPHARMACEUTICAL
1877	DO NOT CODE SERVICES ESSENTIAL TO PROCEDURE
1878	CODE IS A CPT SEPARATE PROCEDURE
1879	CODE ONLY MORE EXTNSV PROC FOR SAME SITE
1880	W/ AND W/OUT CODES SHLD NOT USED TOGETHER
1881	ANESTH SHLD NOT SEP WHEN ADMIN BY OPER MD
1882	DO NOT CODE LAB SERV SEP;CODE LAB PANEL
1883	REPORT CODE FOR COMPLETED SERVICE ONLY
1884	DO NOT CODE SERVICES INTEGRAL TO PROCEDURE
1885	CODES-NOT BE REPRTD TOGETHER PER CPT GUIDE
1886	CODES-NOT BE REPRTD TOGETHER PER DEFINITION
1887	THESE SERV NOT TYPICALLY PERFORMD TOGETHER
1888	MEDICARE IP PSYCHIATRIC ONLY INVALID ALC
1889	MEDICARE IP PSYCH;# OF ECT TXS NOT CODED
1890	MEDICARE IP PSYCH;INVALID OCCUR SPAN
1891	MEDICARE IP PSYCH;ECT UNITS W/O ICD9 PRC
1892	MEDICARE LONG TERM CARE ONLY
1893	POA INDICATOR IS REQUIRED
1894	DIFFERENCE BETWEEN PRIVATE & SEMI-PRIVATE ROOM RATE NOT COVERED
1895	INVALID BILL TYPE (EASYGROUP)
1896	DENIAL CLAIM (EASYGROUP)
1897	INVALID SERVICE DATES OR FROM-THRU DATES (EASYGROUP)
1898	CLAIM DENIED, REJECTED, OR RTP BY ACE (EASYGROUP)
1899	INVALID PARTIAL HOSPITALIZATION CLAIM (EASYGROUP)
1900	INCORRECT BILLING OF REVENUE CODE WITH HCPCS (EASYGROUP)
1901	MENTAL HEALTH CODE NOT APPROVED FOR PARTIAL HOSPITALIZATION PROGRAM (EASYGROUP)
1902	MENTAL HEALTH SERVICE NOT PAYABLE OUTSIDE PARTIAL HOSPITALIZATION PROGRAM (EASYGROUP)
1903	CHARGES EXCEEDS TOKEN CHARGE($1.01) (EASYGROUP)
1904	SERVICE PROVIDED ON OR ATER EFFECTIVE DATE OF NCD NON-COVERAGE (EASYGROUP)
1905	PCN MATCH FOUND, DUPLICATE CLAIM
1906	PCN MATCH FOUND, MULTIPLE DUPLICATE CLAIMS
1907	DIAGNOSIS/GENDER CONFLICT (EASYGROUP)
1908	MEDICARE AS SECND PAYER ALERT (EASYGROUP)
1909	E-CODE AS REASON FOR VISIT (EASYGROUP)
1910	NO HIPPS CODE ON CLAIM (EASYGROUP)
1911	PRICER TYPE NOT LICENSED (EASYGROUP)
1912	TOTAL UNITS EXCEED PATIENTS LENGTH OF STAY (EASYGROUP)
1913	MEDSNF RECORD NOT FOUND (EASYGROUP)
1914	NO WEIGHTS (EASYGROUP)
1915	ERROR READING MEDSNF FILE (EASYGROUP)
1916	ERROR READING RATESNF FILE (EASYGROUP)
1917	ERROR READING FEE SCHEDULE FILE (EASYGROUP)
1918	INITIALIZATION ERROR (EASYGROUP)
1919	ERROR ALLOCATING MEMORY (EASYGROUP)
1920	PARAMETER PASSING ERROR (EASYGROUP)
1921	INVALID DIAGNOSIS (EASYGROUP)
1922	DIAGNOSIS/AGE CONFLICT (EASYGROUP)
1923	COMPUTED AGE IS GREATER THATN 140 YEARS (EASYGROUP)
1924	SUBMITTED AGE IS INVALID (EASYGROUP)
1925	BIRTH DATE BEFORE ADMISSION DATE/FROM DATE(EASYGROUP)
1926	INVALID BIRTH DATE (EASYGROUP)
1927	INVALID ADMISSION DATE/FROM DATE(EASYGROUP)
1928	SELF CARE, EATING (FIM39A, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1929	SELF CARE, GROOMING (FIM39B, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1930	SELF CARE, BATHING (FIM39C, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1931	SELF CARE, DRESSING UPPER BODY(FIM39D, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1932	SELF CARE, DRESSING LOWER BODY(FIM39E, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1933	SELF CARE, TOILETING(FIM39F, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1934	SPHINCTER CONTROL, BLADDER MANAGEMENT (FIM39G, ADM VALUE) IS OUT OF RANGE(EASYGROUP)
1935	SPHINCTER CONTROL, BOWEL MANAGEMENT (FIM39H, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1936	TRANSFERS, BED,CHAIR, WHEELCHAIR(FIM39I, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1937	TRANSFERS, TOILET(FIM39J, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1938	LOCOMOTION, WALK/WHEELCHAIR(FIM39L, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1939	LOCOMOTION, STAIRS(FIM39M, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1940	COMPREHENSION(FIM39N, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1941	EXPRESSION(FIM39O, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1942	SOCIAL INTERACTION(FIM39P, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1943	PROBLEM SOLVING(FIM39Q, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1944	MEMORY(FIM39R, ADM VALUE) IS OUT OF RANGE (EASYGROUP)
1945	IMPAIRMENT GROUP CODE IS INVALID (EASYGROUP)

1946	TOTAL MOTOR SCORE, ADMISSION, OUT OF RANGE (EASYGROUP)
1947	TOTAL COGNITIVE SCORE, ADMISSION, OUT OF RANGE(EASYGROUP)
1948	NO CMG RATE RECORD(EASYGROUP)
1949	INVALID PAYOR TYPE (EASYGROUP)
1950	LOS VALUE REQUIRED, MUST BE GREATER THAN ZERO (EASYGROUP)
1951	LOS < (THRUDATE - FROMDATE) AND NON-INTERRUPTED STAY(EASYGROUP)
1952	DISCHARGE STATUS IS INVALID/MISSING (EASYGROUP)
1953	CMG/HIPPS CODE MISSING(EASYGROUP)
1954	RIC CODE INVALID(EASYGROUP)
1955	CMG/HIPPS ALOS IS MISSING; REQUIRED FOR TRANFER CALCULATION(EASYGROUP)
1956	NO MATCHING ACE OVERRIDE ID FOUND IN ACERULE FILE (EASYGROUP)
1957	NO APG RATE RECORD (EASYGROUP)
1958	MEDICARE INPATIENT PSYCHIATRIC ONLY INVALID ALC (EASYGROUP)
1959	MEDICARE INPATIENT PSYCHIATRIC ONLY;# OF ECT TREATMENTS NOT CODED (EASYGROUP)
1960	MEDICARE INPATIENT PSYCHIATRIC ONLY; INVALID OCCURANCE SPAN (EASYGROUP)
1961	MEDICARE INPATIENT PSYCHIATRIC ONLY; ECT UNITS W/O ICD-9 PRC (EASYGROUP)
1962	MEDICARE LONG TERM CARE ONLY (EASYGROUP)
1963	PRESENT ON ADMISSION INDICATOR IS REQUIRED BUT IS INVALID (EASYGROUP)
1964	N434-MISSING/INCOMPLETE/INVALID PRESENT ON ADMISSION INDICATOR - 1964
1966	MBR PROG PARTIC FALLS W/IN SERV DATE SPAN
1967	TAXONOMY CODE IS INVALID FOR SERV DATES
1968	INVALID ADMISSION AND/OR DISCHARGE DATE (EASYGROUP)
1969	PROMPT PAY PROVIDER CLAIM
1970	PCN MATCH FOUND, DUPLICATE CLAIM
1971	PCN MATCH FOUND, MULTIPLE DUPLICATE CLAIMS
1972	B4-LATE FILING PENALTY
1973	N211-YOU MAY NOT APPEAL THIS DECISION
1974	25.3-APPEAL RIGHTS NOT APPLIC FOR CLAIM
1975	REVIEW FOR POSSIBLE MEDICARE TIMELY FILING EXCEPTION
1976	REVIEW POSS TIMELY FILING EXCEP
1977	29-FILING TIME LIMIT HAS EXPIRED(MEDICARE)
1978	FILING TIME LIMIT HAS EXPIRED
1979	LATE FILING PENALTY
1980	ADMISSION DATE IS LESS THAN CLAIM FROM DATE
1981	ADMISSION DATE IS GREATER THAN CLAIM TO DATE
1982	DISCHARGE DATE IS GREATER THAN CLAIM TO DATE
1983	DISCHARGE DATE IS LESS THAN CLAIM FROM DATE
1984	DIAGNOSIS 5 INDICATES POSSIBLE WORKERS COMPENSATION/AUTO CLAIM
1985	DIAGNOSIS 5 INDICATES POSSIBLE DENTAL CLAIM
1986	DIAGNOSIS 6 INDICATES POSSIBLE WORKERS COMPENSATION/AUTO CLAIM
1987	DIAGNOSIS 6 INDICATES POSSIBLE DENTAL CLAIM
1988	DIAGNOSIS 7 INDICATES POSSIBLE WORKERS COMPENSATION/AUTO CLAIM
1989	DIAGNOSIS 7 INDICATES POSSIBLE DENTAL CLAIM
1990	DIAGNOSIS 8 INDICATES POSSIBLE WORKERS COMPENSATION/AUTO CLAIM
1991	DIAGNOSIS 8 INDICATES POSSIBLE DENTAL CLAIM
1992	CLAIMCHECK EXPANDED ERROR FILE I/O ERROR
1993	ASSISTANT SURGEON IS SOMETIMES ACCEPTABLE FOR THIS PROCEDURE, PLEASE REVIEW
1994	ASSISTANT AT SURGERY IS SOMETIMES ACCEPTABLE FOR THIS PROCEDURE, PLEASE REVIEW
1995	ASSISTANT AT SURGERY DENIED FOR THIS PROCEDURE
1996	CCI (OR OCE) INCIDENTAL PROCEDURE; SHOULD NOT BE REIMBURSED
1997	CCI (OR OCE) MUTUALLY EXCLUSIVE PROCEDURE; SHOULD NOT BE REIMBURSED
1998	PROCEDURE WOULD HAVE DENIED BUT MODIFIER OVERRODE EDIT, PLEASE REVIEW
1999	CMS REQUIRES 9 DIGIT PROVIDER ZIP CODE TO PROPERLY PRICE SERVICES
2000	SERVICE LINE COB REQUIRED/MISSING
2001	PAYMENT IS SUBJECT TO DIAGNOSTIC IMAGING CAP
2002	UPN IS REQUIRED FOR THE PROCEDURE CODE
2003	PROCEDURE CODE DOES NOT ALLOW A UPN
2004	UPN/NDC IS NOT VALID FOR THE PROCEDURE CODE
2005	UPN IS VALID FOR THE PROCEDURE CODE BUT NOT FOR THE SERVICE DATE
2006	DUPLICATE OF IN PROCESS CLAIM
2007	DUPLICATE OF SUSPENDED CLAIM
2008	NDC IS REQUIRED FOR PROCEDURE CODE
2009	PROCEDURE CODE DOES NOT ALLOW A NDC
2010	PCN MATCH FOUND, DUPLICATE OF IN PROCESS CLAIM
2011	PCN MATCH FOUND, DUPLICATE OF SUSPENDED CLAIM
2012	THIS CLAIM IS A REPLACEMENT OF CLAIM ID
2013	>1000 BENEFITS ELIGIBLE FOR SERVICES ON CLAIM
2014	CLAIM SUSPENDED (EASYGROUP)
2015	RETURN CLAIM TO PROV TO CORRECT (RTP)(EASYGROUP)
2016	CLAIM REJECTED (EASYGROUP)
2017	CLAIM DENIED (EASYGROUP)
2018	CONDITION CODE 21 (EASYGROUP)
2019	INVALID FROM/THRU DATES (EASYGROUP)
2020	DATE OUT OF OCE RANGE (EASYGROUP)
2021	INVALID AGE (EASYGROUP)
2022	INVALID SEX (EASYGROUP)
2023	ONLY INCIDENTAL SERVICES REPORTED (EASYGROUP)
2024	PARTIAL HOSP, NON-MENTAL-HEALTH DX (EASYGROUP)
2025	INSUFFICIENT PARTIAL HOSP SERVICES (EASYGROUP)
2026	PHP SERV W/ PAYSTAT T SERVICE (EASYGROUP)
2027	PHP <4 DAYS W/ INSUFF/INAPPR SERV(EASYGROUP)
2028	PHP >3 DAYS W/ INSUFF PHP SERVICES (EASYGROUP)
2029	PHP >3 DAYS W/ INAPPROPRIATE SERV(EASYGROUP)
2030	ONLY MH ED/TX SERV PROVIDED 1 OR MORE DAYS (EASYGROUP)
2031	EXTNSVE MH SERV PROVDED PAYSTAT T SERV (EASYGROUP)
2032	PHP COND CODE INVLD FOR BILL TYPE (EASYGROUP)
2033	TOTAL CHARGES AMOUNT DOES NOT MATCH TOTAL SERVICE LINE CHARGES
2034	UPN VALUE IS INVALID
2035	NDC VALUE IS INVALID

2036	BUNDLED/NON COVERED OR OTHER CODE AVAILABLE
2037	REASON FOR VISIT 1 VALUE OR QUALIFIER IS INVALID
2038	REASON FOR VISIT 2 VALUE OR QUALIFIER IS INVALID
2039	REASON FOR VISIT 3 VALUE OR QUALIFIER IS INVALID
2040	NON-EXEMPT PROVIDER - REQUIRED PRESENT ON ADMISSION INDICATOR MISSING
2041	ADMIT DIAGNOSIS/AGE CONFLICT (EASYGROUP)
2042	ADMIT DIAGNOSIS/GENDER CONFLICT (EASYGROUP)
2043	PROCEDURE NOT FOUND IN CODE TABLE (EASYGROUP)
2044	PROCEDURE NOT VALID FOR SERVICE DATE (EASYGROUP)
2045	SERVICES PAID UNDER FEE SCHEDULE OR OTHER PROSPECTIVELY DETERMINED RATE (EASYGROUP)
2046	SERVICE NOT ALLOWED UNDER OPPS ON HOSPITAL OUTPATIENT CLAIM (EASYGROUP)
2047	INPATIENT SERVICE, NOT PAID UNDER OPPS (EASYGROUP)
2048	NON-COVERED SERVICE, NOT PAID UNDER OPPS (EASYGROUP)
2049	CORNEAL, CRNA AND HEPATITIS B (EASYGROUP)
2050	DRUG/BIOLOGICAL PASS-THROUGH (EASYGROUP)
2051	PASS-THROUGH DEVICE, BRACHYTHERAPY SOURCE, RADIOPHARMACEUTICALS (EASYGROUP)
2052	NEW DRUG/BIOLOGICAL, TRANSITIONAL PASS-THROUGH PAYMENT (EASYGROUP)
2053	NON-PASS-THROUGH DRUGS AND BIOLOGICALS (EASYGROUP)
2054	INFLUENZA VIRUS OR PNEUMOCOCCAL PNEUMONIA VACCINE(PPV) (EASYGROUP)
2055	SERVICE NOT BILLABLE TO THE FI/MAC (EASYGROUP)
2056	PACKAGED/INCIDENTAL SERVICE (EASYGROUP)
2057	PARTIAL HOSPITALIZATION SERVICE (EASYGROUP)
2058	PACKAGED SERVICE SUBJECT TO SEPARATE PAYMENT BASED ON PAYMENT CRITERIA (EASYGROUP)
2059	SIGNIFICANT PROCEDURE, NOT SUBJECT TO DISCOUNTING (EASYGROUP)
2060	SIGNIFICANT PROCEDURE, SUBJECT TO DISCOUNTING (EASYGROUP)
2061	CLINIC OR EMERGENCY DEPARTMENT VISIT (EASYGROUP)
2062	INVALID HCPCS, OR BLANK HCPCS AND INVALID REVENUE CODE (EASYGROUP)
2063	ANCILLARY SERVICE (EASYGROUP)
2064	NON-IMPLANTABLE DME (EASYGROUP)
2065	VALID REVENUE CODE, BLANK HCPCS, NO OTHER STATUS INDICATOR ASSIGNED (EASYGROUP)
2066	CONDITIONALLY BILATERAL (EASYGROUP)
2067	INHERENTLY BILATERAL (EASYGROUP)
2068	INDEPENDENTLY BILATERAL (EASYGROUP)
2069	NOT BILATERAL (EASYGROUP)
2070	PACKAGED SERVICE (EASYGROUP)
2071	PACKAGED AS PART OF PARTIAL HOSPITALIZATION OR MENTAL HEALTH PER DIEM (EASYGROUP)
2072	SURGICAL CHARGES ARE LESS THAN $0.01 (EASYGROUP)
2073	PACKAGED AS PART OF DRUG ADMINISTRATION APC PAYMENT (EASYGROUP)
2074	PACKAGED AS PART OF COMPOSITE APC (EASYGROUP)
2075	DIAGNOSIS CODE #10 IS INVALID
2076	DIAGNOSIS CODE #11 IS INVALID
2077	DIAGNOSIS CODE #12 IS INVALID
2078	DIAGNOSIS CODE #13 IS INVALID
2079	DIAGNOSIS CODE #14 IS INVALID
2080	DIAGNOSIS CODE #15 IS INVALID
2081	DIAGNOSIS CODE #16 IS INVALID
2082	DIAGNOSIS CODE #17 IS INVALID
2083	DIAGNOSIS CODE #18 IS INVALID
2084	DIAGNOSIS CODE #19 IS INVALID
2085	DIAGNOSIS CODE #20 IS INVALID
2086	DIAGNOSIS CODE #21 IS INVALID
2087	DIAGNOSIS CODE #22 IS INVALID
2088	DIAGNOSIS CODE #23 IS INVALID
2089	DIAGNOSIS CODE #24 IS INVALID
2090	DIAGNOSIS CODE #10 IS NOT VALID FOR DATE
2091	DIAGNOSIS CODE #11 IS NOT VALID FOR DATE
2092	DIAGNOSIS CODE #12 IS NOT VALID FOR DATE
2093	DIAGNOSIS CODE #13 IS NOT VALID FOR DATE
2094	DIAGNOSIS CODE #14 IS NOT VALID FOR DATE
2095	DIAGNOSIS CODE #15 IS NOT VALID FOR DATE
2096	DIAGNOSIS CODE #16 IS NOT VALID FOR DATE
2097	DIAGNOSIS CODE #17 IS NOT VALID FOR DATE
2098	DIAGNOSIS CODE #18 IS NOT VALID FOR DATE
2099	DIAGNOSIS CODE #19 IS NOT VALID FOR DATE
2100	DIAGNOSIS CODE #20 IS NOT VALID FOR DATE
2101	DIAGNOSIS CODE #21 IS NOT VALID FOR DATE
2102	DIAGNOSIS CODE #22 IS NOT VALID FOR DATE
2103	DIAGNOSIS CODE #23 IS NOT VALID FOR DATE
2104	DIAGNOSIS CODE #24 IS NOT VALID FOR DATE
2105	TOTAL NON-COVERED AMOUNT DOES NOT MATCH TOTAL SERVICE LINE NON-COVERED AMOUNT
2106	DIAGNOSIS CODE #25 IS INVALID
2107	DIAGNOSIS CODE #25 IS NOT VALID FOR DATE
2108	CLAIM DX VERSION DOES NOT MATCH SERVICE DIAGNOSIS DX VERSION(S)
2109	CLOSED OR INACTIVE RATE RECORD (EASYGROUP)
2110	CLAIM DATES < 01/01/2008 AND NO HOSPITAL RATE FOUND (EASYGROUP)
2111	CLAIM DATES >= 01/01/2008 AND NO HOSPITAL RATE FOUND (EASYGROUP)
2112	CONFIGURATION/HOSPITAL RATE FILES ARE OUT OF SYNCH (EASYGROUP)
2113	HAC EDITOR NOT FOUND (EASYGROUP)
2114	GROUPER INITIALIZATION ERROR (EASYGROUP)
2115	GROUPER ERROR COLLECTING MEMORY(EASYGROUP)
2116	NO CMG MATCH(EASYGROUP)
2117	NON-COVERED CLAIM - MEDICARE INPATIENT(EASYGROUP)
2118	NON-PAYMENT CLAIM PER DRG GUIDELINES (EASYGROUP)
2119	CLAIM CONTAINS NEVER EVENT - NEW YORK STATE(EASYGROUP)
2120	WRONG PROCEDURE PERFORMED - MEDICARE INPATIENT, TRICARE YORK STATE(EASYGROUP)
2121	INVALID REIMBURSEMENT CONFIGURATION - MULTI-PRICER/DRG PRO(EASYGROUP)
2122	INVALID BIOPSY CODE (EASYGROUP)
2123	RESERVED FOR CREDIT/ADJUSTMENT CLAIM (EASYGROUP)
2124	INVALID HOME HEALTH CLAIM DATES (EASYGROUP)

2125	INVALID NUMBER OF HIPPS CODES (EASYGROUP)
2126	HIPPS CODE INDICATED NRS WERE PROVIDED, BUT NRS NOT ON CLAIM(EASYGROUP)
2127	INVALID OR MISSING CBSA(EASYGROUP)
2128	FINAL CLAIM MUST HAVE AT LEAST ONE VISIT-RELATED REVENUE CODE(EASYGROUP)
2129	NO AVAILABLE HHRG WEIGHT/RATE (EASYGROUP)
2130	INCORRECT BILLING OF AMCC ESRD-RELATED TESTS (EASYGROUP)
2131	INVALID BILLING OF THERAPY SERVICES (EASYGROUP)
2132	INVALID BILL TYPE NOT 18X,21X,22X OR 23X (EASYGROUP)
2133	SERVICE DATE INVALID OR OUT OF RANGE (EASYGROUP)
2134	CLAIM SPANS CALENDAR YEAR (EASYGROUP)
2135	INVALID BILLING OF THERAPY SERVICES (EASYGROUP)
2136	CLAIM SPANS > 365 DAYS (EASYGROUP)
2137	SERVICE SUBMITTED FOR FI/MAC REVIEW - CONDITION CODE 20(EASYGROUP)
2138	INSUFFICIENT PARTIAL HOSPITALIZATION SERVICES (EASYGROUP)
2139	STVX - PACKAGED SERVICES (EASYGROUP)
2140	T - PACKAGED SERVICES (EASYGROUP)
2141	SERVICES THAT MAY BE PAID THROUGH A COMPOSITE APC (EASYGROUP)
2142	BLOOD AND BLOOD PRODUCTS (EASYGROUP)
2143	BRACHYTHERAPY SOURCES (EASYGROUP)
2144	DATE IN HOSPEXT FILE DOES NOT MATCH HOSPRATE FILE(EASYGROUP)
2145	MISSING DIAGNOSIS CODE (EASYGROUP)
2146	INVALID CASE-MIX ADJUSTMENT (EASYGROUP)
2147	ATTEMPTED DIVIDE BY ZERO (EASYGROUP)
2148	CONFIGURATION RECORD ERROR/OUT OF SYNCH (EASYGROUP)
2149	MEDEXT RECORD NOT FOUND(EASYGROUP)
2150	N434-MISSING/INCOMPLETE/INVALID PRESENT ON ADMISSION INDICATOR - 2150
2151	E-CODE 1 VALUE OR QUALIFIER IS INVALID
2152	E-CODE 2 VALUE OR QUALIFIER IS INVALID
2153	E-CODE 3 VALUE OR QUALIFIER IS INVALID
2154	CODES INDICATE MUTUALLY EXCLUSIVE SERVICES(EASYGROUP)
2155	NON-EXEMPT PROVIDER - REQUIRED PRESENT ON ADMISSION INDICATOR MISSING(EDI)
2156	UNKNOWN RETURN CODE FROM CLAIM CHECK
2159	PROCEDURE TO DIAGNOSIS PROCEDURE DENIED (CLAIM REVIEW)
2160	MEDICALLY UNNECESSARY PROCEDURE DENIED (CLAIM REVIEW)
2161	CLAIM REVIEW - PROCEDURE TO DIAGNOSIS DENIAL
2162	CLAIM REVIEW - PROCEDURE TO DIAGNOSIS SUSPEND
2163	CLAIM REVIEW - PROCEDURE TO DIAGNOSIS MONITOR
2164	INVALID BILLING OF CARDIAC RESYNC THERAPY CODES(EASYGROUP)
2165	CLAIM SUSPENDED DUE TO W9 PROVIDER TO BE PAID VALIDATION
2166	SERVICE HAS EXCEEDED FEE SCHEDULE MAXIMUM PER DAY
2167	FEE SCHEDULE MAXIMUM PER DAY EXCEEDED ON PREVIOUSLY PAID SERVICE/CLAIM
2168	PRINCIPAL DIAGNOSIS CODE IS NOT VALID FOR DATE
2169	ADMIT DIAGNOSIS CODE IS NOT VALID FOR DATE
2170	OTHER DIAGNOSIS CODE #1 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2171	OTHER DIAGNOSIS CODE #2 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2172	OTHER DIAGNOSIS CODE #3 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2173	OTHER DIAGNOSIS CODE #4 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2174	OTHER DIAGNOSIS CODE #5 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2175	OTHER DIAGNOSIS CODE #6 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2176	OTHER DIAGNOSIS CODE #7 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2177	OTHER DIAGNOSIS CODE #8 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2178	OTHER DIAGNOSIS CODE #9 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2179	OTHER DIAGNOSIS CODE #10 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2180	OTHER DIAGNOSIS CODE #11 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2181	OTHER DIAGNOSIS CODE #12 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2182	OTHER DIAGNOSIS CODE #13 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2183	OTHER DIAGNOSIS CODE #14 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2184	OTHER DIAGNOSIS CODE #15 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2185	OTHER DIAGNOSIS CODE #16 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2186	OTHER DIAGNOSIS CODE #17 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2187	OTHER DIAGNOSIS CODE #18 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2188	OTHER DIAGNOSIS CODE #19 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2189	OTHER DIAGNOSIS CODE #20 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2190	OTHER DIAGNOSIS CODE #21 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2191	OTHER DIAGNOSIS CODE #22 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2192	OTHER DIAGNOSIS CODE #23 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2193	OTHER DIAGNOSIS CODE #24 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2194	OTHER DIAGNOSIS CODE #25 IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2195	ADMIT DIAGNOSIS CODE IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2196	AGE OR GENDER AND PRINCIPAL DIAGNOSIS ARE INCONSISTENT
2197	AGE OR GENDER AND ADMIT DIAGNOSIS ARE INCONSISTENT
2198	AGE OR GENDER AND OTHER DIAGNOSIS #1 ARE INCONSISTENT
2199	AGE OR GENDER AND OTHER DIAGNOSIS #2 ARE INCONSISTENT
2200	AGE OR GENDER AND OTHER DIAGNOSIS #3 ARE INCONSISTENT
2201	AGE OR GENDER AND OTHER DIAGNOSIS #4 ARE INCONSISTENT
2202	AGE OR GENDER AND OTHER DIAGNOSIS #5 ARE INCONSISTENT
2203	AGE OR GENDER AND OTHER DIAGNOSIS #6 ARE INCONSISTENT
2204	AGE OR GENDER AND OTHER DIAGNOSIS #7 ARE INCONSISTENT
2205	AGE OR GENDER AND OTHER DIAGNOSIS #8 ARE INCONSISTENT
2206	AGE OR GENDER AND OTHER DIAGNOSIS #9 ARE INCONSISTENT
2207	AGE OR GENDER AND OTHER DIAGNOSIS #10 ARE INCONSISTENT
2208	AGE OR GENDER AND OTHER DIAGNOSIS #11 ARE INCONSISTENT
2209	AGE OR GENDER AND OTHER DIAGNOSIS #12 ARE INCONSISTENT
2210	AGE OR GENDER AND OTHER DIAGNOSIS #13 ARE INCONSISTENT
2211	AGE OR GENDER AND OTHER DIAGNOSIS #14 ARE INCONSISTENT
2212	AGE OR GENDER AND OTHER DIAGNOSIS #15 ARE INCONSISTENT
2213	AGE OR GENDER AND OTHER DIAGNOSIS #16 ARE INCONSISTENT
2214	AGE OR GENDER AND OTHER DIAGNOSIS #17 ARE INCONSISTENT
2215	AGE OR GENDER AND OTHER DIAGNOSIS #18 ARE INCONSISTENT

2216	AGE OR GENDER AND OTHER DIAGNOSIS #19 ARE INCONSISTENT
2217	AGE OR GENDER AND OTHER DIAGNOSIS #20 ARE INCONSISTENT
2218	AGE OR GENDER AND OTHER DIAGNOSIS #21 ARE INCONSISTENT
2219	AGE OR GENDER AND OTHER DIAGNOSIS #22 ARE INCONSISTENT
2220	AGE OR GENDER AND OTHER DIAGNOSIS #23 ARE INCONSISTENT
2221	AGE OR GENDER AND OTHER DIAGNOSIS #24 ARE INCONSISTENT
2222	AGE OR GENDER AND OTHER DIAGNOSIS #25 ARE INCONSISTENT
2223	PRINCIPAL DIAGNOSIS IS DUPLICATE OF SECONDARY DIAGNOSIS
2224	ADMIT DIAGNOSIS IS DUPLICATE OF SECONDARY DIAGNOSIS
2225	OTHER DIAGNOSIS #1 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2226	OTHER DIAGNOSIS #2 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2227	OTHER DIAGNOSIS #3 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2228	OTHER DIAGNOSIS #4 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2229	OTHER DIAGNOSIS #5 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2230	OTHER DIAGNOSIS #6 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2231	OTHER DIAGNOSIS #7 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2232	OTHER DIAGNOSIS #8 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2233	OTHER DIAGNOSIS #9 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2234	OTHER DIAGNOSIS #10 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2235	OTHER DIAGNOSIS #11 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2236	OTHER DIAGNOSIS #12 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2237	OTHER DIAGNOSIS #13 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2238	OTHER DIAGNOSIS #14 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2239	OTHER DIAGNOSIS #15 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2240	OTHER DIAGNOSIS #16 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2241	OTHER DIAGNOSIS #17 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2242	OTHER DIAGNOSIS #18 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2243	OTHER DIAGNOSIS #19 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2244	OTHER DIAGNOSIS #20 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2245	OTHER DIAGNOSIS #21 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2246	OTHER DIAGNOSIS #22 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2247	OTHER DIAGNOSIS #23 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2248	OTHER DIAGNOSIS #24 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2249	OTHER DIAGNOSIS #25 IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2250	PRINCIPAL DIAGNOSIS POA INDICATOR REQUIRED
2251	ADMIT DIAGNOSIS POA INDICATOR REQUIRED
2252	OTHER DIAGNOSIS #1 POA INDICATOR REQUIRED
2253	OTHER DIAGNOSIS #2 POA INDICATOR REQUIRED
2254	OTHER DIAGNOSIS #3 POA INDICATOR REQUIRED
2255	OTHER DIAGNOSIS #4 POA INDICATOR REQUIRED
2256	OTHER DIAGNOSIS #5 POA INDICATOR REQUIRED
2257	OTHER DIAGNOSIS #6 POA INDICATOR REQUIRED
2258	OTHER DIAGNOSIS #7 POA INDICATOR REQUIRED
2259	OTHER DIAGNOSIS #8 POA INDICATOR REQUIRED
2260	OTHER DIAGNOSIS #9 POA INDICATOR REQUIRED
2261	OTHER DIAGNOSIS #10 POA INDICATOR REQUIRED
2262	OTHER DIAGNOSIS #11 POA INDICATOR REQUIRED
2263	OTHER DIAGNOSIS #12 POA INDICATOR REQUIRED
2264	OTHER DIAGNOSIS #13 POA INDICATOR REQUIRED
2265	OTHER DIAGNOSIS #14 POA INDICATOR REQUIRED
2266	OTHER DIAGNOSIS #15 POA INDICATOR REQUIRED
2267	OTHER DIAGNOSIS #16 POA INDICATOR REQUIRED
2268	OTHER DIAGNOSIS #17 POA INDICATOR REQUIRED
2269	OTHER DIAGNOSIS #18 POA INDICATOR REQUIRED
2270	OTHER DIAGNOSIS #19 POA INDICATOR REQUIRED
2271	OTHER DIAGNOSIS #20 POA INDICATOR REQUIRED
2272	OTHER DIAGNOSIS #21 POA INDICATOR REQUIRED
2273	OTHER DIAGNOSIS #22 POA INDICATOR REQUIRED
2274	OTHER DIAGNOSIS #23 POA INDICATOR REQUIRED
2275	OTHER DIAGNOSIS #24 POA INDICATOR REQUIRED
2276	OTHER DIAGNOSIS #25 POA INDICATOR REQUIRED
2277	PRINCIPAL DIAGNOSIS POA INDICATOR IS INVALID
2278	ADMIT DIAGNOSIS POA INDICATOR IS INVALID
2279	OTHER DIAGNOSIS #1 POA INDICATOR IS INVALID
2280	OTHER DIAGNOSIS #2 POA INDICATOR IS INVALID
2281	OTHER DIAGNOSIS #3 POA INDICATOR IS INVALID
2282	OTHER DIAGNOSIS #4 POA INDICATOR IS INVALID
2283	OTHER DIAGNOSIS #5 POA INDICATOR IS INVALID
2284	OTHER DIAGNOSIS #6 POA INDICATOR IS INVALID
2285	OTHER DIAGNOSIS #7 POA INDICATOR IS INVALID
2286	OTHER DIAGNOSIS #8 POA INDICATOR IS INVALID
2287	OTHER DIAGNOSIS #9 POA INDICATOR IS INVALID
2288	OTHER DIAGNOSIS #10 POA INDICATOR IS INVALID
2289	OTHER DIAGNOSIS #11 POA INDICATOR IS INVALID
2290	OTHER DIAGNOSIS #12 POA INDICATOR IS INVALID
2291	OTHER DIAGNOSIS #13 POA INDICATOR IS INVALID
2292	OTHER DIAGNOSIS #14 POA INDICATOR IS INVALID
2293	OTHER DIAGNOSIS #15 POA INDICATOR IS INVALID
2294	OTHER DIAGNOSIS #16 POA INDICATOR IS INVALID
2295	OTHER DIAGNOSIS #17 POA INDICATOR IS INVALID
2296	OTHER DIAGNOSIS #18 POA INDICATOR IS INVALID
2297	OTHER DIAGNOSIS #19 POA INDICATOR IS INVALID
2298	OTHER DIAGNOSIS #20 POA INDICATOR IS INVALID
2299	OTHER DIAGNOSIS #21 POA INDICATOR IS INVALID
2300	OTHER DIAGNOSIS #22 POA INDICATOR IS INVALID
2301	OTHER DIAGNOSIS #23 POA INDICATOR IS INVALID
2302	OTHER DIAGNOSIS #24 POA INDICATOR IS INVALID
2303	OTHER DIAGNOSIS #25 POA INDICATOR IS INVALID
2304	PRINCIPAL DIAGNOSIS POA INDICATOR INVALID FOR THIS EXEMPT CODE

2305	ADMIT DIAGNOSIS POA INDICATOR INVALID FOR THIS EXEMPT CODE
2306	OTHER DIAGNOSIS #1 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2307	OTHER DIAGNOSIS #2 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2308	OTHER DIAGNOSIS #3 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2309	OTHER DIAGNOSIS #4 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2310	OTHER DIAGNOSIS #5 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2311	OTHER DIAGNOSIS #6 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2312	OTHER DIAGNOSIS #7 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2313	OTHER DIAGNOSIS #8 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2314	OTHER DIAGNOSIS #9 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2315	OTHER DIAGNOSIS #10 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2316	OTHER DIAGNOSIS #11 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2317	OTHER DIAGNOSIS #12 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2318	OTHER DIAGNOSIS #13 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2319	OTHER DIAGNOSIS #14 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2320	OTHER DIAGNOSIS #15 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2321	OTHER DIAGNOSIS #16 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2322	OTHER DIAGNOSIS #17 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2323	OTHER DIAGNOSIS #18 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2324	OTHER DIAGNOSIS #19 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2325	OTHER DIAGNOSIS #20 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2326	OTHER DIAGNOSIS #21 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2327	OTHER DIAGNOSIS #22 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2328	OTHER DIAGNOSIS #23 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2329	OTHER DIAGNOSIS #24 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2330	OTHER DIAGNOSIS #25 POA INDICATOR INVALID FOR THIS EXEMPT CODE
2331	DIAGNOSIS CODE IS DUPLICATE OF PRINCIPAL DIAGNOSIS
2332	DIAGNOSIS CODE IS DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS
2333	DIAGNOSIS CODE POA INDICATOR REQUIRED
2334	DIAGNOSIS CODE POA INDICATOR INVALID
2335	DIAGNOSIS CODE POA INDICATOR INVALID FOR THIS EXEMPT CODE
2336	PRINCIPAL DIAGNOSIS CODE IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2337	ADMIT DIAGNOSIS CODE IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2338	OTHER DIAGNOSIS CODE #1 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2339	OTHER DIAGNOSIS CODE #2 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2340	OTHER DIAGNOSIS CODE #3 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2341	OTHER DIAGNOSIS CODE #4 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2342	OTHER DIAGNOSIS CODE #5 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2343	OTHER DIAGNOSIS CODE #6 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2344	OTHER DIAGNOSIS CODE #7 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2345	OTHER DIAGNOSIS CODE #8 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2346	OTHER DIAGNOSIS CODE #9 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2347	OTHER DIAGNOSIS CODE #10 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2348	OTHER DIAGNOSIS CODE #11 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2349	OTHER DIAGNOSIS CODE #12 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2350	OTHER DIAGNOSIS CODE #13 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2351	OTHER DIAGNOSIS CODE #14 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2352	OTHER DIAGNOSIS CODE #15 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2353	OTHER DIAGNOSIS CODE #16 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2354	OTHER DIAGNOSIS CODE #17 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2355	OTHER DIAGNOSIS CODE #18 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2356	OTHER DIAGNOSIS CODE #19 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2357	OTHER DIAGNOSIS CODE #20 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2358	OTHER DIAGNOSIS CODE #21 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2359	OTHER DIAGNOSIS CODE #22 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2360	OTHER DIAGNOSIS CODE #23 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2361	OTHER DIAGNOSIS CODE #24 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2362	OTHER DIAGNOSIS CODE #25 IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2363	PRINCIPAL DIAGNOSIS CODE IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2364	ADMIT DIAGNOSIS CODE IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2365	OTHER DIAGNOSIS CODE #1 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2366	OTHER DIAGNOSIS CODE #2 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2367	OTHER DIAGNOSIS CODE #3 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2368	OTHER DIAGNOSIS CODE #4 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2369	OTHER DIAGNOSIS CODE #5 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2370	OTHER DIAGNOSIS CODE #6 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2371	OTHER DIAGNOSIS CODE #7 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2372	OTHER DIAGNOSIS CODE #8 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2373	OTHER DIAGNOSIS CODE #9 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2374	OTHER DIAGNOSIS CODE #10 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2375	OTHER DIAGNOSIS CODE #11 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2376	OTHER DIAGNOSIS CODE #12 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2377	OTHER DIAGNOSIS CODE #13 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2378	OTHER DIAGNOSIS CODE #14 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2379	OTHER DIAGNOSIS CODE #15 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2380	OTHER DIAGNOSIS CODE #16 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2381	OTHER DIAGNOSIS CODE #17 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2382	OTHER DIAGNOSIS CODE #18 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2383	OTHER DIAGNOSIS CODE #19 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2384	OTHER DIAGNOSIS CODE #20 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2385	OTHER DIAGNOSIS CODE #21 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2386	OTHER DIAGNOSIS CODE #22 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2387	OTHER DIAGNOSIS CODE #23 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2388	OTHER DIAGNOSIS CODE #24 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2389	OTHER DIAGNOSIS CODE #25 IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2390	PRINCIPAL DIAGNOSIS CODE IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2391	ADMIT DIAGNOSIS CODE IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2392	OTHER DIAGNOSIS CODE #1 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2393	OTHER DIAGNOSIS CODE #2 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT

2394	OTHER DIAGNOSIS CODE #3 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2395	OTHER DIAGNOSIS CODE #4 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2396	OTHER DIAGNOSIS CODE #5 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2397	OTHER DIAGNOSIS CODE #6 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2398	OTHER DIAGNOSIS CODE #7 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2399	OTHER DIAGNOSIS CODE #8 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2400	OTHER DIAGNOSIS CODE #9 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2401	OTHER DIAGNOSIS CODE #10 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2402	OTHER DIAGNOSIS CODE #11 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2403	OTHER DIAGNOSIS CODE #12 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2404	OTHER DIAGNOSIS CODE #13 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2405	OTHER DIAGNOSIS CODE #14 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2406	OTHER DIAGNOSIS CODE #15 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2407	OTHER DIAGNOSIS CODE #16 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2408	OTHER DIAGNOSIS CODE #17 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2409	OTHER DIAGNOSIS CODE #18 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2410	OTHER DIAGNOSIS CODE #19 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2411	OTHER DIAGNOSIS CODE #20 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2412	OTHER DIAGNOSIS CODE #21 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2413	OTHER DIAGNOSIS CODE #22 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2414	OTHER DIAGNOSIS CODE #23 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2415	OTHER DIAGNOSIS CODE #24 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2416	OTHER DIAGNOSIS CODE #25 IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2417	DIAGNOSIS CODE IS HAC ELIGIBLE, ANOTHER CC/MCC IS PRESENT
2418	DIAGNOSIS CODE IS HAC ELIGIBLE, BUT IS NOT CC/MCC
2419	DIAGNOSIS CODE IS HAC ELIGIBLE, NO OTHER CC/MCC IS PRESENT
2420	PRINCIPAL DIAGNOSIS CODE IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2421	ADMIT DIAGNOSIS CODE IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2422	OTHER DIAGNOSIS CODE #1 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2423	OTHER DIAGNOSIS CODE #2 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2424	OTHER DIAGNOSIS CODE #3 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2425	OTHER DIAGNOSIS CODE #4 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2426	OTHER DIAGNOSIS CODE #5 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2427	OTHER DIAGNOSIS CODE #6 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2428	OTHER DIAGNOSIS CODE #7 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2429	OTHER DIAGNOSIS CODE #8 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2430	OTHER DIAGNOSIS CODE #9 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2431	OTHER DIAGNOSIS CODE #10 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2432	OTHER DIAGNOSIS CODE #11 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2433	OTHER DIAGNOSIS CODE #12 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2434	OTHER DIAGNOSIS CODE #13 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2435	OTHER DIAGNOSIS CODE #14 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2436	OTHER DIAGNOSIS CODE #15 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2437	OTHER DIAGNOSIS CODE #16 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2438	OTHER DIAGNOSIS CODE #17 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2439	OTHER DIAGNOSIS CODE #18 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2440	OTHER DIAGNOSIS CODE #19 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2441	OTHER DIAGNOSIS CODE #20 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2442	OTHER DIAGNOSIS CODE #21 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2443	OTHER DIAGNOSIS CODE #22 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2444	OTHER DIAGNOSIS CODE #23 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2445	OTHER DIAGNOSIS CODE #24 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2446	OTHER DIAGNOSIS CODE #25 IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2447	PRINCIPAL DIAGNOSIS CODE IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2448	ADMIT DIAGNOSIS CODE IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2449	OTHER DIAGNOSIS CODE #1 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2450	OTHER DIAGNOSIS CODE #2 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2451	OTHER DIAGNOSIS CODE #3 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2452	OTHER DIAGNOSIS CODE #4 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2453	OTHER DIAGNOSIS CODE #5 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2454	OTHER DIAGNOSIS CODE #6 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2455	OTHER DIAGNOSIS CODE #7 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2456	OTHER DIAGNOSIS CODE #8 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2457	OTHER DIAGNOSIS CODE #9 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2458	OTHER DIAGNOSIS CODE #10 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2459	OTHER DIAGNOSIS CODE #11 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2460	OTHER DIAGNOSIS CODE #12 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2461	OTHER DIAGNOSIS CODE #13 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2462	OTHER DIAGNOSIS CODE #14 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2463	OTHER DIAGNOSIS CODE #15 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2464	OTHER DIAGNOSIS CODE #16 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2465	OTHER DIAGNOSIS CODE #17 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2466	OTHER DIAGNOSIS CODE #18 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2467	OTHER DIAGNOSIS CODE #19 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2468	OTHER DIAGNOSIS CODE #20 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2469	OTHER DIAGNOSIS CODE #21 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2470	OTHER DIAGNOSIS CODE #22 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2471	OTHER DIAGNOSIS CODE #23 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2472	OTHER DIAGNOSIS CODE #24 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2473	OTHER DIAGNOSIS CODE #25 IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2474	DIAGNOSIS CODE IS CC FOR MEDICARE MS-DRG ASSIGNMENT
2475	DIAGNOSIS CODE IS MCC FOR MEDICARE MS-DRG ASSIGNMENT
2476	PRINCIPAL DIAGNOSIS CODE INDICATES A WRONG PROCEDURE WAS PERFORMED
2477	ADMIT DIAGNOSIS CODE INDICATES A WRONG PROCEDURE WAS PERFORMED
2478	OTHER DIAGNOSIS CODE #1 INDICATES A WRONG PROCEDURE WAS PERFORMED
2479	OTHER DIAGNOSIS CODE #2 INDICATES A WRONG PROCEDURE WAS PERFORMED
2480	OTHER DIAGNOSIS CODE #3 INDICATES A WRONG PROCEDURE WAS PERFORMED
2481	OTHER DIAGNOSIS CODE #4 INDICATES A WRONG PROCEDURE WAS PERFORMED
2482	OTHER DIAGNOSIS CODE #5 INDICATES A WRONG PROCEDURE WAS PERFORMED

2483	OTHER DIAGNOSIS CODE #6 INDICATES A WRONG PROCEDURE WAS PERFORMED
2484	OTHER DIAGNOSIS CODE #7 INDICATES A WRONG PROCEDURE WAS PERFORMED
2485	OTHER DIAGNOSIS CODE #8 INDICATES A WRONG PROCEDURE WAS PERFORMED
2486	OTHER DIAGNOSIS CODE #9 INDICATES A WRONG PROCEDURE WAS PERFORMED
2487	OTHER DIAGNOSIS CODE #10 INDICATES A WRONG PROCEDURE WAS PERFORMED
2488	OTHER DIAGNOSIS CODE #11 INDICATES A WRONG PROCEDURE WAS PERFORMED
2489	OTHER DIAGNOSIS CODE #12 INDICATES A WRONG PROCEDURE WAS PERFORMED
2490	OTHER DIAGNOSIS CODE #13 INDICATES A WRONG PROCEDURE WAS PERFORMED
2491	OTHER DIAGNOSIS CODE #14 INDICATES A WRONG PROCEDURE WAS PERFORMED
2492	OTHER DIAGNOSIS CODE #15 INDICATES A WRONG PROCEDURE WAS PERFORMED
2493	OTHER DIAGNOSIS CODE #16 INDICATES A WRONG PROCEDURE WAS PERFORMED
2494	OTHER DIAGNOSIS CODE #17 INDICATES A WRONG PROCEDURE WAS PERFORMED
2495	OTHER DIAGNOSIS CODE #18 INDICATES A WRONG PROCEDURE WAS PERFORMED
2496	OTHER DIAGNOSIS CODE #19 INDICATES A WRONG PROCEDURE WAS PERFORMED
2497	OTHER DIAGNOSIS CODE #20 INDICATES A WRONG PROCEDURE WAS PERFORMED
2498	OTHER DIAGNOSIS CODE #21 INDICATES A WRONG PROCEDURE WAS PERFORMED
2499	OTHER DIAGNOSIS CODE #22 INDICATES A WRONG PROCEDURE WAS PERFORMED
2500	OTHER DIAGNOSIS CODE #23 INDICATES A WRONG PROCEDURE WAS PERFORMED
2501	OTHER DIAGNOSIS CODE #24 INDICATES A WRONG PROCEDURE WAS PERFORMED
2502	OTHER DIAGNOSIS CODE #25 INDICATES A WRONG PROCEDURE WAS PERFORMED
2503	DIAGNOSIS CODE INDICATES A WRONG PROCEDURE WAS PERFORMED
2504	REASON FOR VISIT 1 IS NOT VALID FOR DATE
2505	REASON FOR VISIT 2 IS NOT VALID FOR DATE
2506	REASON FOR VISIT 3 IS NOT VALID FOR DATE
2507	AGE OR GENDER AND REASON FOR VISIT 1 ARE INCONSISTENT
2508	AGE OR GENDER AND REASON FOR VISIT 2 ARE INCONSISTENT
2509	AGE OR GENDER AND REASON FOR VISIT 3 ARE INCONSISTENT
2510	REASON FOR VISIT 1 IS DUPLICATE OF ANOTHER REASON FOR VISIT
2511	REASON FOR VISIT 2 IS DUPLICATE OF ANOTHER REASON FOR VISIT
2512	REASON FOR VISIT 3 IS DUPLICATE OF ANOTHER REASON FOR VISIT
2513	PRINCIPAL PROCEDURE CODE IS INVALID
2514	OTHER PROCEDURE CODE #1 IS INVALID
2515	OTHER PROCEDURE CODE #2 IS INVALID
2516	OTHER PROCEDURE CODE #3 IS INVALID
2517	OTHER PROCEDURE CODE #4 IS INVALID
2518	OTHER PROCEDURE CODE #5 IS INVALID
2519	PRINCIPAL PROCEDURE CODE IS NOT VALID FOR DATE
2520	OTHER PROCEDURE CODE #1 IS NOT VALID FOR DATE
2521	OTHER PROCEDURE CODE #2 IS NOT VALID FOR DATE
2522	OTHER PROCEDURE CODE #3 IS NOT VALID FOR DATE
2523	OTHER PROCEDURE CODE #4 IS NOT VALID FOR DATE
2524	OTHER PROCEDURE CODE #5 IS NOT VALID FOR DATE
2525	INVALID PATIENT SEX FOR PRINCIPAL PROCEDURE CODE
2526	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #1
2527	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #2
2528	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #3
2529	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #4
2530	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #5
2531	NON-COVERED PRINCIPAL PROCEDURE CODE
2532	NON-COVERED OTHER PROCEDURE CODE #1
2533	NON-COVERED OTHER PROCEDURE CODE #2
2534	NON-COVERED OTHER PROCEDURE CODE #3
2535	NON-COVERED OTHER PROCEDURE CODE #4
2536	NON-COVERED OTHER PROCEDURE CODE #5
2537	OPEN BIOPSY PRINCIPAL PROCEDURE CODE
2538	OPEN BIOPSY OTHER PROCEDURE CODE #1
2539	OPEN BIOPSY OTHER PROCEDURE CODE #2
2540	OPEN BIOPSY OTHER PROCEDURE CODE #3
2541	OPEN BIOPSY OTHER PROCEDURE CODE #4
2542	OPEN BIOPSY OTHER PROCEDURE CODE #5
2543	LIMITED COVERAGE PRINCIPAL PROCEDURE CODE
2544	LIMITED COVERAGE OTHER PROCEDURE CODE #1
2545	LIMITED COVERAGE OTHER PROCEDURE CODE #2
2546	LIMITED COVERAGE OTHER PROCEDURE CODE #3
2547	LIMITED COVERAGE OTHER PROCEDURE CODE #4
2548	LIMITED COVERAGE OTHER PROCEDURE CODE #5
2549	BILATERAL PRINCIPAL PROCEDURE CODE
2550	BILATERAL OTHER PROCEDURE CODE #1
2551	BILATERAL OTHER PROCEDURE CODE #2
2552	BILATERAL OTHER PROCEDURE CODE #3
2553	BILATERAL OTHER PROCEDURE CODE #4
2554	BILATERAL OTHER PROCEDURE CODE #5
2555	HSS CANNOT DETERMINE CODING VERSION (ICD9/ICD10) FOR CLAIM
2556	INVALID OR MISSING REQUIRED CLAIMS DATA (EASYGROUP)
2557	PATIENT REFUSES TO ASSIGN BENEFITS
2558	PER-DAY RATE ALREADY PAID FOR THIS SERVICE DATE
2559	PER-DAY RATE ALREADY PAID, APPLIED DIFFERENCE BETWEEN RATES
2560	REDUCTION-FEDERAL BUDGET SEQUESTRATION
2562	PRINCIPAL DIAGNOSIS CODE IS REQUIRED
2563	INVALID HIPPS CODE
2564	CLAIM SUSPENDED - PROVIDER DID NOT ACCEPT BENEFITS ASSIGNMENT
2565	POINT OF PICK-UP ZIP CODE REQUIRED FOR THIS CLAIM TYPE
2566	POINT OF PICK-UP ZIP CODE NOT FOUND ON THE ZIP CODE MAINTENANCE TABLE
2567	RURAL MILEAGE 1-17 RATE NEEDED AND DOES NOT EXIST FOR THIS PROCEDURE
2568	SUPER RURAL RATE NEEDED AND DOES NOT EXIST FOR THIS PROCEDURE
2569	NUMBER OF PATIENTS REQUIRED FOR MULTIPLE PATIENT TRANSPORTS
2570	VALUE CODE 32 FOR NUMBER OF PATIENTS IS REQUIRED FOR MULTIPLE PATIENT TRANSPORT
2571	SURGICAL PROCEDURE; OPPS WEIGHT (EASYGROUP)
2572	NON OFFICE-BASED PROCEDURE; OPPS WEIGHT(EASYGROUP)

2573	CORNEAL TISSUE ACQUISTION, HEP B VACCINE; REASONABLE COST(EASYGROUP)
2574	BRACHYTHERAPY SOURCE; OPPS RATE COST(EASYGROUP)
2575	BRACHYTHERAPY SOURCE; CONTRACTOR RATE(EASYGROUP)
2576	DEVICE-INTENSIVE PROCEDURE; ADJUSTED RATE(EASYGROUP)
2577	OPPS PASS-THROUGH DEVICE; CONTRACTOR RATE(EASYGROUP)
2578	DEVICE-INTENSIVE PROCEDURE; ADJUSTED RATE(EASYGROUP)
2579	DRUG/BIOLOGICAL; OPPS RATE(EASYGROUP)
2580	UNCLASS DRUG/BIOLOGICAL; CONTRATOR PRICED(EASYGROUP)
2581	INFLUENZA/PNEUMOCOCCAL VACCINE; PACKAGED SERVICE(EASYGROUP)
2582	NEW TECH INTRAOCULAR LENS; SPECIAL PAYMENT(EASYGROUP)
2583	QUALITY MEASUREMENT CODE USE FOR REPORTING PURPOSE ONLY; NO PAYMENT(EASYGROUP)
2584	PACKAGED SERVICE/ITEM; NO SEPARATE PAYMENT(EASYGROUP)
2585	OFFICE-BASED PROCEDURE; OPPS WEIGHT(EASYGROUP)
2586	OFFICE-BASED PROCEDURE; MPFS RVUS(EASYGROUP)
2587	SERVICE NOT COVERED BY MEDICARE FOR FREE-STANDING ASC(EASYGROUP)
2588	RADIOLOGY SERVICE; OPPS WEIGHT(EASYGROUP)
2589	RADIOLOGY SERVICE; MPFS NON-FACILITY PE RVUS(EASYGROUP)
2590	RENTALS EXCEED MAXIMUM PURCHASE PRICE
2591	TENS RENTAL PERIOD EXCEEDED
2592	RENTALS FOR THIS ITEM ARE CAPPED AT 15
2593	THE BENEFICIARY MUST SELECT A RENTAL OR PURCHASE OPTION TO CONTINUE PAYMENT
2594	PROCEDURE REQUIRES NEW OR USED MODIFIER
2595	SERVICES INCLUDED IN ESRD COMPOSITE RATE
2596	NO NDC CODE REPORTED FOR THE NOC DRUG SERVICE
2597	ICD-9 PROCEDURE CODES NOT ALLOWED ON CLAIMS ON OR AFTER CUTOFF DATE
2598	ICD-9 DIAGNOSIS CODES NOT ALLOWED ON CLAIMS ON OR AFTER CUTOFF DATE
2599	ICD-10 PROCEDURE CODES NOT ALLOWED ON CLAIMS BEFORE CUTOFF DATE
2600	ICD-10 DIAGNOSIS CODES NOT ALLOWED ON CLAIMS BEFORE CUTOFF DATE
2601	ICD-9 AND ICD-10 PROCEDURE CODES NOT ALLOWED ON SAME CLAIM
2602	ICD-9 AND ICD-10 DIAGNOSIS CODES NOT ALLOWED ON SAME CLAIM
2603	ACT - MISSING ACCOUNT ID
2604	ACW - ANESTHESIA CROSSWALK
2605	ANE - ANESTHESIA PERFORMED BY NON-ANESTHESIA PROVIDER
2606	ASD-ANESTHESIA ALREADY PAID FOR THE SAME DOS
2607	ASH - ANESTHESIA SECONDARY PROCEDURE - HISTORY
2608	BAG - NOT PAYABLE FOR PATIENT'S AGE PER CMS LCD
2609	BCC - LCD PART B CODE TO CODE MISSING OR INVALID
2610	BCD - LCD PART B MISSING OR INVALID CODE TO CODE DIAGNOSIS
2611	BCM - LCD PART B MISSING OR INVALID CODE TO CODE MODIFIER
2612	BCP - LCD PART B MISSING OR INVALID CODE TO CODE PROCEDURE
2613	BDS - MISSING OR INVALID DATE OF SERVICE
2614	BFR - LCD PART B PROCEDURE FREQUENCY EXCEEDED
2615	BNC - LCD PART B NON COVERED CODE
2616	BPO - LCD PART B MISSING REQUIRED PLACE OF SERVICE
2617	BPR - BILATERAL PROCEDURE REDUCTION
2618	BPS - MISSING OR INVALID PLACE OF SERVICE
2619	BRR - ANESTHESIA CROSSWALK - BY REPORT
2620	BSP - PER PART B LCD- INVALID PROVIDER SPECIALTY
2621	BSX - PROCEDURE INCONSISTENT WITH THE PATIENT GENDER PER PART B LCD
2622	CAG - PROCEDURE INCONSISTENT WITH THE PATIENT AGE
2623	CDL - PROCEDURE CODE PLACE OF SERVICE
2624	COS - COSMETIC PROCEDURES ARE NOT PAYABLE
2625	CPT - PROCEDURE CODE IS INVALID FOR DATE OF SERVICE
2626	CSX - PROCEDURE IS INCONSISTENT WITH THE PATIENT'S GENDER
2627	D59 - DOCUMENTATION NEEDED WITH MODIFIER 59
2628	DAP - DENY ADD-ON PROCEDURE
2629	DCM - ICD-10 TO ICD-9 DIAGNOSIS COMPARISON
2630	DLP - DUPLICATE SERVICE LINE
2631	DOB - MISSING OR INVALID DATE OF BIRTH
2632	DTU - NUMBER OF UNITS EXCEED THE FROM AND THROUGH DATE
2633	DUP - DUPLICATE CLAIM
2634	GFP - BUNDLED SERVICE -CLAIM LINE FALLS WITHIN THE GLOBAL FOLLOW UP PERIOD
2635	GRP - RETAINED PROCEDURE CODE FROM TRANSFER
2636	GSP - BUNDLED SERVICE - CLAIM IS WITHIN POST OPERATIVE PERIOD
2637	HEX - HISTORY UNBUNDLE PROCEDURE - EXCLUSIVE
2638	HIN - HISTORY UNBUNDLE PROCEDURE - INCIDENTAL
2639	HNB - HISTORY UNBUNDLE PROCEDURE - UNBUNDLE OR INCIDENTAL
2640	HRB - HISTORY REBUNDLE
2641	HRP - HISTORY PROCEDURE CODE RETAINED FROM TRANSFER
2642	IAG - DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
2643	IAP - DIAGNOSISIS INCONSISTENT WITH THE PROCEDURE BILLED
2644	ICD - INVALID DIAGNOSIS CODE
2645	ICM - MISSING DIAGNOSIS CODE
2646	ICR - ANESTHESIA CROSSWALK - INDIVIDUAL REVIEW
2647	IDX - INVALID DIAGNOSIS CODE
2648	IMC - INAPPROPRIATE MODIFIER COMBINATION
2649	IMD - INAPPROPRIATE MODIFIER TO DIAGNOSIS
2650	IMO - INVALID MODIFIER
2651	INV - INVESTIGATIONAL/EXPERIMENTAL PROCEDURE IS NOT PAYABLE
2652	ISX - DIAGNOSIS CODE INCONSISTENT WITH PATIENT GENDER
2653	LBI - REQUIRED DIAGNOSIS MISSING PER PART B LCD
2654	LBM - MISSING REQUIRED MODIFIER PER MEDICARE PART B LCD
2655	LBN - REQUIRED DIAGNOSIS NOT IN THE PRIMARY POSITION PER PART B LCD
2656	LBP - MISSING THE REQUIRED DIAGNOSIS CODE PER PART B LCD
2657	LBS - MISSING THE REQUIRED SECONDARY DIAGNOSIS CODE PER MEDICARE PART LCD
2658	LTP - MISSING THE REQUIRED TERTIARY DIAGNOSIS PER MEDICARE PART B LCD
2659	LCD - PART B LCD POLICY REQUIREMENTS NOT MET
2660	LDY - PART B LCD REQUIREMENTS NOT MET
2661	LPF - LCD REQUIREMENTS MET

2662	LRD - LCD PART B REVIEW/REQUEST DOCUMENTS
2663	M26 - MODIFIER REQUIRED FOR PAYMENT
2664	MAM - MEDICARE AMBULANCE MODIFIER REQUIRED
2665	MANE - MEDICARE ANESTHESIA REDUCTION
2666	MANM - MEDICARE ANESTHESIA MODIFIER MISSING
2667	MAP - MEDICARE DENY ADD-ON PROCEDURE
2668	MAS - ASSISTANT SURGEONS ARE NOT PAYABLE FOR THIS SERVICE
2669	MB2 - MEDICARE BILATERAL ADJUSTMENT DOES NOT APPLY
2670	MBC - MEDICARE BUNDLED CODE
2671	MBI - MEDICARE BUNDLED ITEM OR SERVICE
2672	MBP - MEDICARE BILATERAL PROCEDURE REDUCTION
2673	MCO - MEDICARE CO-SURGEONS NOT PERMITTED
2674	MD1 - MEDICARE DOCUMENT ASSISTANT SURGEON
2675	MD2 - MEDICARE DOCUMENT CO-SURGEONS
2676	MD3 - MEDICARE DOCUMENT TEAM SURGERY
2677	MDEY - MODIFIER EY DENIED PER CMS POLICY
2678	MDF - MEDICARE DME MAXIMIUM FREQUENCY REACHED
2679	MDFH - MEDICARE DME MAXIMUM FREQUENCY IN HISTORY
2680	MDR - MEDICARE DIAGNOSTIC RADIOLOGY REDUCTION
2681	MDRH - MEDICARE DIAGNOSTIC RADIOLOGY REDUCTION - HISTORY
2682	MDT-TECHNICAL COMPONENT NOT PAYABLE TO PHYSICIAN FOR THIS POS
2683	MEH - MEDICARE E/M AND SURGERY WITHOUT MODIFIER - HISTORY
2684	MEM - E&M BUNDLED WITH MAJOR/MINOR PROCEDURE
2685	MER - MEDICARE MULTIPLE ENDOSCOPY REDUCTION
2686	MERH - MEDICARE BILATERAL PROCEDURE REDUCTION - HISTORY
2687	MEV - E&M PREVIOUSLY PAID FOR DOS SAME PROVIDER
2688	MFD - DAILY FREQUENCY EXCEEDED
2689	MFL - INFLUENZA VACCINE MISSING DIAGNOSIS REQUIRED BY CMS
2690	MFP - CLAIM WITHIN MEDICARE GLOBAL FOLLOW-UP BY PROVIDER
2691	MFPH - MEDICARE GLOBAL FOLLOW UP BY PROVIDER IN HISTORY
2692	MFX - MAXIMUM FREQUENCY EXCEEDED
2693	MFXH - MAXIMUM FREQUENCY EXCEEDED IN HISTORY
2694	MGT - SPLIT BILLING IS NOT ALLOWED
2695	MHB - MEDICARE HEPATITIS B VACCINE REQUIRES DIAGNOSIS
2696	MIC - BUNDLED: INCIDENTAL PROCEDURE
2697	MIM - MEDICARE INAPPROPRIATE MODIFIER
2698	MIN - BUNDLED PROCEDURE
2699	MM54 - MEDICARE INTRAOPERATIVE CARE ONLY
2700	MM55 - MEDICARE POSTOPERATIVE CARE ONLY
2701	MM56 - MEDICARE PREOPERATIVE CARE ONLY
2702	MM78 - MANUAL PRICING - MEDICARE RETURN TO OPERATING ROOM
2703	MMEY - PER CMS GUIDELINES, ALL CLAIM LINES ON THE SAME CLAIM MUST CONTAIN THE MODIFIER EY
2704	MMGK -CMS POLICY FOR THE USE OF MODIFIER GK HAS NOT BEEN MET
2705	MMGY - MODIFIER GY NOT PAYABLE PER MEDICARE GUIDELINES
2706	MMGZ - MODIFIER DENIED PER GZ POLICY
2707	MMOD - MEDICARE MODIFIER INVALID FOR PROCEDURE
2708	MMP - MEDICARE MULTIPLE PROCEDURE REDUCTION
2709	MMP5 - MEDICARE MULTIPLE PROCEDURE REDUCTION - OVER 5 PROCEDURES
2710	MMPH - MEDICARE MULTIPLE PROCEDURE REDUCTION - HISTORY
2711	MMUE - MEDICARE MEDICALLY UNLIKELY EDITS
2712	MNC-MEDICARE NON-COVERED HCPCS AND MODIFIER
2713	MNE - ERRONEOSLY PERFORMED AS REPORTED ON THE CLAIM. NOT COVERED
2714	MNP - INCIDENTAL/BUNDLED WHEN PROVIDED IN POS BILLED
2715	MNS - PROCEDURE CODE 1 IS NOT COVERED BY MEDICARE
2716	MNV - NOT VALID FOR BILLING MEDICARE (STATUS INDICATOR I)
2717	MOD - MODIFIER NOT APPROPRIATE WITH PROCEDURE
2718	MPC - INVALID MODIFIER SPLIT BILLING IS NOT ALLOWED FOR THIS SERVICE LINE
2719	MPD - MEDICARE PROFESSIONAL DIAGNOSTIC RADIOLOGY REDUCTION
2720	MPDH - MEDICARE PROFESSIONAL DIAGNOSTIC RADIOLOGY REDUCTION - HISTORY
2721	MPI - INVALID MODIFIER. SPLIT BILING IS NOT ALLOWED FOR THIS SERVICE LINE
2722	MPN - MEDICARE PNEUMOCOCCAL VACCINE MISSING REQUIRED DIAGNOSIS
2723	MPR - MULTIPLE PROCEDURE REDUCTION
2724	MPS - INVALID MODIFIER CONCEPT OF PROFESSIONAL AND TECHNICAL DOES NOT APPLY
2725	MPT - PLACE OF SERVICE INVALID FOR PHYSICAL THERAPY SERVICE. SEE CMS POLICY
2726	MSB - MEDICARE ADD-ON PROCEDURE WITHOUT PRIMARY PROCEDURE
2727	MSP - BUNDLED AS INCLUDED IN THE POST OP PERIOD
2728	MSPH - MEDICARE POST-OP RELATED SURGERY BY PROVIDER IN HISTORY
2729	MTC - INVALID MODIFIER -CONCEPT OF PROFESSIONAL AND TECHNICAL DOES NOT APPLY
2730	MTF - MEDICARE TIMELY FILING EDITS EXCEEDED
2731	MTR - MEDICARE MULTIPLE THERAPY REDUCTION
2732	MTRH - MEDICARE MULTIPLE THERAPY REDUCTION - HISTORY
2733	MTS -TEAM SURGEONS NOT PERMITTED PER MEDICARE POLICY
2734	MUB- BUNDLED PER MEDICARE POLICY
2735	MUBH - MEDICARE OTHER UNBUNDLE IN HISTORY
2736	MUH - MEDICARE CCI UNBUNDLE - HISTORY
2737	MUH2 - BUNDLED BASED MEDICARE POLICY
2738	MUN - BUNDLED BASED ON MEDICARE POLICY
2739	MUN2 - BUNDLED BASED ON MEDICARE POLIC
2740	NCS - NON-COVERED SERVICE
2741	NPD - NOT A PRIMARY DIAGNOSIS CODE
2742	NPT - NEW PATIENT CODE BILLED FOR ESTABLISHED PATIENT
2743	PAT - MISSING PATIENT ID
2744	PCM - INVALID PROFESSIONAL COMPONENT MODIFIER
2745	POS - PLACE OF SERVICE NOT TYPICAL WITH PROCEDURE
2746	PRD - ASSIST/CO/TEAM SURG REDUCTION
2747	PRE - BUNDLED: INCLUDED IN GLOBAL PROCEDURE PERIOD
2748	PRH - PRE-OP PROCEDURE ONE DAY BEFORE SURGERY - HISTORY
2749	PRV - PROVIDER RECORD DOES NOT HAVE AN ACTIVE NPI FOR THE DOS - REQUIRES REVIEW
2750	PSX - MISSING PATIENT GENDER

2751	REB - REBILL WITH COMPREHENSIVE CODE
2752	SAM - MULTIPLE ASSISTANT SURGEONS NOT ALLOWED
2753	SAS- SURGICAL ASSISTANT NOT ALLOWED
2754	SB2 - MEDICAID BILATERAL PAYMENT ADJUSTMENT
2755	SBP - MEDICAID BILATERAL PAYMENT REDUCTION
2756	SDR - MEDICAID DIAGNOSTIC RADIOLOGY REDUCTION
2757	SDRH - MEDICAID DIAGNOSTIC RADIOLOGY REDUCTION - HISTORY
2758	SER - MEDICAID MULTIPLE ENDOSCOPY REDUCTION
2759	SERH - MEDICAID MULTIPLE ENDOSCOPY REDUCTION - HISTORY
2760	SMP - MEDICAID MULTIPLE PROCEDURE REDUCTION
2761	SMP5 - MEDICAID MULTIPLE PROCEDURE REDUCTION - OVER 5 PROCEDURES
2762	SMPH - MEDICAID MULTIPLE PROCEDURE REDUCTION - HISTORY
2763	SMUE - MEDICAID MEDICALLY UNLIKELY EDITS
2764	SPD - MEDICAID PROFESSIONAL DIAGNOSTIC RADIOLOGY REDUCTION
2765	SPDH - MEDICAID PROFESSIONAL DIAGNOSTIC RADIOLOGY REDUCTION - HISTORY
2766	SUB - BUNDLED PROCEDURE
2767	SUH - MEDICAID NATIONAL CORRECT CODING INITIATIVE EDITS IN HISTORY
2768	SUN- BUNDLED PROCEDURE. MEDICAID NCCI EDITS APPLIED
2769	TPL - THIRD PARTY LIABILITY DIAGNOSIS
2770	TRA - REVIEW FOR RE-BUNDLE CODE FOR REB
2771	UEX - BUNDLED PROCEDURE: EXCLUSIVE PROCEDURES BILLED ON THE SAME DOS
2772	UIN - BUNDLED PROCEDURE. INCIDENTAL.
2773	UNB - BUNDLED PROCEDURE
2774	UNL - UNLISTED PROCEDURE CODE
2775	001ICM - INVALID DIAGNOSIS CODE
2776	002IAG - DIAGNOSIS AND AGE CONFLICT
2777	003ISX - DIAGNOSIS AND SEX CONFLICT
2778	004MSA - MEDICARE AS SECONDARY PAYER ALERT
2779	005EPD - E-CODE INVALID AS REASON FOR VISIT
2780	006IPC - INVALID HCPCS PROCEDURE
2781	007CAG - PROCEDURE IS INVALID FOR THE PATIENT'S AGE
2782	008CSX - PROCEDURE IS INVALID FOR THE PATIENT'S SEX
2783	009NCS - NON-COVERED SERVICE
2784	00AGAC - INPATIENT ADMISSION DIAGNOSIS AGE AND GENDER CONFLICT
2785	00OGAC - INPATIENT OTHER DIAGNOSIS AGE AND GENDER CONFLICT
2786	00PGAC - INPATIENT PRINCIPAL DIAGNOSIS AGE AND GENDER CONFLICT
2787	010DNY - NON-COVERED SERVICE SUBMITTED FOR VERIFICATION OF DENIAL (CONDITION CODE 21)
2788	011SFR - NON-COVERED SERVICE SUBMITTED FOR REVIEW (CONDITION CODE 20)
2789	012QCS - QUESTIONABLE COVERED SERVICE
2790	013NSP - ADDITIONAL PAYMENT FOR SERVICES NOT PROVIDED BY MEDICARE
2791	014ISS - SITE OF SERVICE NOT INCLUDED IN OPPS
2792	015MFD - MULTIPLE BILATERAL PROCEDURES WITHOUT MODIFIER 50
2793	016MBP - MULTIPLE BILATERAL PROCEDURES WITHOUT MODIFIER 50
2794	017IBP - INAPPROPRIATE SPECIFICATION OF BILATERAL PROCEDURE
2795	018INP - INPATIENT PROCEDURE
2796	019HMEP - MUTUALLY EXCLUSIVE PROCEDURE NOT ALLOWED
2797	019MEP - MUTUALLY EXCLUSIVE PROCEDURE NOT ALLOWED
2798	01ADID - INPATIENT INVALID ADMISSION DIAGNOSIS
2799	01AID - INPATIENT INVALID ADMISSION DIAGNOSIS
2800	01AMD - INPATIENT INVALID ADMISSION DIAGNOSIS
2801	01OAIP - INPATIENT INVALID OTHER PROCEDURE
2802	01ODID - INPATIENT INVALID OTHER DIAGNOSIS
2803	01ODIP - INPATIENT INVALID OTHER PROCEDURE
2804	01OID - INPATIENT INVALID OTHER DIAGNOSIS
2805	01OIP - INPATIENT INVALID OTHER PROCEDURE
2806	01PAIP - INPATIENT INVALID PRINCIPAL PROCEDURE
2807	01PDID - INPATIENT INVALID PRINCIPAL DIAGNOSIS
2808	01PDIP - INPATIENT INVALID PRINCIPAL PROCEDURE
2809	01PID - INPATIENT INVALID PRINCIPAL DIAGNOSIS
2810	01PIP - INPATIENT INVALID PRINCIPAL PROCEDURE
2811	01PMD - INPATIENT INVALID PRINCIPAL DIAGNOSIS
2812	020CCP - COMPONENT OF COMPREHENSIVE PROCEDURE NOT SEPARATELY ALLOWED
2813	020HCCP - COMPONENT OF COMPREHENSIVE PROCEDURE NOT ALLOWED
2814	021EMO - BUNDLED - MEDICAL VISIT ON SAME DAY AS PROCEDURE
2815	022IMO - INVALID HCPCS MODIFIER
2816	023BDS - THE SERVICE DATE IS NOT WITHIN THE FROM AND THROUGH DATES OF SERVICE ON THE CLAIM
2817	024DOR - DATE OUT OF OCE RANGE
2818	025AGE - INVALID AGE
2819	026SEX - INVALID SEX
2820	027OIS - ONLY INCIDENTAL SERVICE REPORTED
2821	028NRM - CODE NOT RECOGNIZED BY MEDICARE; ALTERNATE CODE FOR SAME SERVICE MAY BE AVAILABLE
2822	029NMH - PARTIAL HOSPITALIZATION SERVICE FOR NON-MENTAL HEALTH DIAGNOSIS
2823	030PHI - INSUFFICIENT SERVICES ON DAY OF PARTIAL HOSPITALIZATION
2824	031PHE - PARTIAL HOSPITALIZATION ON SAME DAY AS ELECTRO-CONVULSIVE THERAPY (ECT) OR SIGNIFICANT PROCEDURE
2825	032PHS - PARTIAL HOSPITALIZATION WHICH SPANS THREE OR LESS DAYS AND HAS INSUFFICIENT MENTAL HEALTH SERVICES
2826	033PHM - PARTIAL HOSPITALIZATION CLAIM SPANS MORE THAN 3 DAYS WITH INSUFFICIENT NUMBER OF DAYS HAVING MENTAL
2827	034PHN - PARTIAL HOSPITALIZATION CLAIM SPANS MORE THAN 3 DAYS WITH INSUFFICIENT NUMBER OF DAYS MEETING PARTIA
2828	035FMS - ONLY ACTIVITY AND/OR OCCUPATIONAL THERAPY SERVICE PROVIDED
2829	036EMS - EXTENSIVE MENTAL HEALTH SERVICE PROVIDED ON DAY OF ELECTROCONVULSIVE THERAPY OR SIGNIFICANT PROCEDURE
2830	037TBP - TERMINATED BILATERAL PROCEDURE OR TERMINATED PROCEDURE WITH UNITS > 1
2831	038IIP - INCONSISTENCY BETWEEN IMPLANTED DEVICE AND IMPLANTATION PROCEDURE
2832	039HMEO - MUTUALLY EXCLUSIVE PROCEDURE
2833	039MEO - MUTUALLY EXCLUSIVE PROCEDURE

2834	03DDC - INPATIENT DUPLICATE PRINCIPAL DIAGNOSIS CODE
2835	03ODDC - INPATIENT DUPLICATE OTHER DIAGNOSIS CODE
2836	040CCO - COMPONENT OF COMPREHENSIVE PROCEDURE
2837	040HCCO - COMPONENT OF COMPREHENSIVE PROCEDURE WOULD BE ALLOWED WITH APPROPRIATE MODIFIER
2838	041IRC - INVALID REVENUE CODE
2839	042MMV - MULTIPLE MEDICAL VISITS ON SAME DAY, SAME REVENUE CODE WITHOUT CONDITION CODE GO
2840	043TBP - BLOOD TRANSFUSION OR BLOOD SERVICE WITHOUT SPECIFICATION OF APPROPRIATE BLOOD PRODUCT
2841	044ORC - OBSERVATION ROOM REVENUE CODE WITHOUT SPECIFICATION OF APPROPRIATE OBSERVATION ROOM SERVICE
2842	045SNA - INPATIENT SEPARATE PROCEDURE IS NOT PAID
2843	046PHC - PARTIAL HOSPITALIZATION CONDITION CODE 41 NOT APPROPRIATE FOR THIS TYPE OF BILL
2844	047SSP - SERVICE IS NOT SEPARATELY PAYABLE
2845	048RRH - REVENUE CODE REQUIRES HCPCS CODE
2846	049SIP - SERVICE ON SAME DAY AS INPATIENT PROCEDURE
2847	04AAGE - INPATIENT ADMISSION DIAGNOSIS AGE CONFLICT
2848	04OAGE - INPATIENT OTHER DIAGNOSIS AGE CONFLICT
2849	04PAGE - INPATIENT DIAGNOSIS AGE CONFLICT
2850	050NCE - NON-COVERED BASED ON STATUTORY EXCLUSION
2851	051MOO - OVERLAPPING OBSERVATION PERIODS (NOT ACTIVATED)
2852	052OCN - OBSERVATION SERVICES NOT SEPARATELY PAYABLE
2853	053OTB - OBSERVATION SERVICE CODE ONLY ALLOWED WITH BILL TYPE 13X
2854	054MCS - MULTIPLE CODES FOR THE SAME SERVICE (NOT ACTIVATED)
2855	055NRS - NOT REPORTABLE FOR THIS SITE OF SERVICE
2856	056OEM - OBSERVATION SERVICE E&M REQUIREMENTS NOT MET, SERVICE DATE NOT 12/31 OR 1/1
2857	057OES - OBSERVATION SERVICE E&M REQUIREMENTS NOT MET, SERVICE DATE 12/31 OR 1/1
2858	058OAP - G0263 ONLY ALLOWED WITH PAYABLE G0244
2859	059CTD - VLINICAL TRIAL REQUIRES DIAGNOSIS CODE V707 AS OTHER THAN PRIMARY DIAGNOSIS
2860	05ADSX - INPATIENT ADMITTING DIAGNOSIS GENDER CONFLICT
2861	05ODSX - INPATIENT OTHER DIAGNOSIS GENDER CONFLICT
2862	05OPSX - INPATIENT OTHER PROCEDURE GENDER CONFLICT
2863	05PDSX - INPATIENT PRINCIPAL DIAGNOSIS GENDER CONFLICT
2864	05PPSX - INPATIENT PRINCIPAL PROCEDURE GENDER CONFLICT
2865	060MCA - USE OF MODIFIER CA WITH MORE THAN ONE PROCEDURE IS NOT ALLOWED
2866	061SBD - CODE CAN ONLY BE BILLED TO THE DME REGIONAL CARRIER
2867	062CNR - CODE NOT ALLOWED UNDER OPPS ALTERNATE MAY BE AVAILABLE
2868	063OPH - OCCUPATIONAL THERAPY CAN ONLY BE BILLED ON PARTIAL HOSPITALIZATION CLAIMS
2869	064TPH - ACTIVITY THERAPY SERVICES ARE NOT PAYABLE OUTSIDE THE PARTIAL HOSPITALIZATION PROGRAM
2870	065RNM - REVENUE CODE NOT RECOGNIZED BY MEDICARE
2871	066CMP - CODE REQUIRES MANUAL PRICING
2872	067SPA - SERVICE PROVIDED PRIOR TO FDA APPROVAL
2873	068PCD - SERVICE PROVIDED PRIOR TO DATE OF NATIONAL COVERAGE DETERMINATION (NCD)
2874	069SOP - SERVICE PROVIDED OUTSIDE LIMITED APPROVAL PERIOD
2875	06AMDC - INPATIENT MANIFESTATION CODE AS ADMIT DX NOT ALLOWED
2876	06PMDC - INPATIENT MANIFESTATION CODE AS PRINCIPAL DX NOT ALLOWED
2877	070CA - CA MODIFIER REQUIRES PATIENT STATUS CODE 20
2878	071CDC - CLAIM LACKS REQUIRED DEVICE CODE
2879	072SNB - SERVICE NOT BILLABLE TO FISCAL INTERMEDIARY
2880	073IBP - INCORRECT BILLING OF BLOOD AND BLOOD PRODUCTS
2881	074UBP - UNITS GREATER THAN ONE FOR BILATERAL PROCEDURE BILLED WITH MODIFIER 50
2882	075IBM - INCORRECT BILLING MODIFIER FB
2883	076TRC - TRAUMA RESPONSE CRITICAL CARE CODE WITHOUT REVENUE CODE 068X AND CPT 99291
2884	077DPC - CLAIM LACKS REQUIRED PROCEDURE CODE
2885	078DNM - CLAIM LACKS REQUIRED HCPCS LEVEL II CODE FOR THE RADIOPHARMACEUTICAL DRUG
2886	079IRC - INCORRECT BILLING OF REVENUE CODE AND BLOOD CODE
2887	080MHA - FACILITY MENTAL HEALTH CODE NOT APPROVED FOR PARTIAL HOSPITALIZATION PROGRAM
2888	081MHP - FACILITY MENTAL HEALTH CODE NOT PAYABLE OUTSIDE THE PARTIAL HOSPITALIZATION PROGRAM
2889	082CET - FACILITY CHARGE EXCEEDS TOKEN CHARGE
2890	083NCD - FACILITY OUTPATIENT SERVICE PROVIDED AFTER NCD COVERAGE DATES
2891	084LPC - FACILITY CLAIM LACKS REQUIRED PRIMARY CODE
2892	085OSD - CLAIM LACKS REQUIRED DEVICE OR PROCEDURE CODE
2893	08QAD - INPATIENT QUESTIONABLE ADMISSION
2894	09OUAD - FACILITY INPATIENT UNACCEPTABLE OTHER DIAGNOSIS
2895	09PUAD - FACILITY INPATIENT UNACCEPTABLE PRINCIPAL DIAGNOSIS
2896	100AEC - AN EXTERNAL CAUSE CODE IS BEING USED AS THE ADMIT DIAGNOSIS CODE
2897	100PEC - AN EXTERNAL CAUSE CODE IS BEING USED AS THE PRINCIPAL DIAGNOSIS CODE
2898	101HSEP - SERVICES ESSENTIAL TO PROCEDURE ARE NOT CODED
2899	101SEP - SERVICES ESSENTIAL TO PROCEDURE ARE NOT CODED
2900	102CSP - CODE IS A CPT SEPARATE PROCEDURE
2901	102HCSP - CODE IS A CPT SEPARATE PROCEDURE
2902	103ESS - CODE ONLY MORE EXTENSIVE SERVICE SAME SITE
2903	103HESS - CODE ONLY MORE EXTENSIVE SERVICE SAME SITE
2904	104HWWC - WITH AND WITHOUT CODES ARE NOT USED TOGETHER
2905	104WWC - WITH AND WITHOUT CODES ARE NOT USED TOGETHER
2906	105AON - ANESTHESIA SHOULD NOT BE REPORTED SEPARATELY WHEN ADMINISTERED BY THE OPERATING PHYSICIAN
2907	105HAON - ANESTHESIA SHOULD NOT BE REPORTED SEPARATELY WHEN ADMINISTERED BY THE OPERATING PHYSICIAN
2908	106HSLP - DO NOT CODE LAB SERVICE SEPARATELY; CODE LAB PANEL
2909	106SLP - DO NOT CODE LAB SERVICE SEPARATELY; CODE LAB PANEL
2910	107CSO - REPORT CODE FOR COMPLETED SERVICE ONLY
2911	107HCSO - REPORT CODE FOR COMPLETED SERVICE ONLY
2912	108HSIP - DO NOT CODE SERVICE INTEGRAL TO PROCEDURE
2913	108SIP - DO NOT CODE SERVICE INTEGRAL TO PROCEDURE
2914	109CCG - THESE CODES SHOULD NOT BE REPORTED TOGETHER PER CPT CODING GUIDELINES
2915	109HCCG - THESE CODES SHOULD NOT BE REPORTED TOGETHER PER CPT CODING GUIDELINES
2916	110HNUT - THESE CODES SHOULD NOT BE USED TOGETHER PER CODE DEFINITION

2917	110NUT - THESE CODES SHOULD NOT BE USED TOGETHER PER CODE DEFINITION
2918	111HNPT - THESE SERVICES ARE NOT TYPICALLY PERFORMED TOGETHER
2919	111NPT - THESE SERVICES ARE NOT TYPICALLY PERFORMED TOGETHER
2920	112HMES - CODES INDICATE MUTUALLY EXCLUSIVE SERVICES
2921	112MES - CODES INDICATE MUTUALLY EXCLUSIVE SERVICES
2922	113HISC - CODES INDICATE SEX CONFLICT
2923	113ISC - CODES INDICATE SEX CONFLICT
2924	114MES - CODES INDICATE MUTUALLY EXCLUSIVE SERVICES
2925	115CCE - BUNDLED -COLUMN 1/COLUMN 2 CORRECT CODING EDITS
2926	11ANCP - FACILITY INPATIENT NON COVERED WITH AGE
2927	11DNCP - FACILITY INPATIENT NON COVERED PROCEDURE WITH DIAGNOSIS
2928	11NCP - FACILITY INPATIENT NON COVERED PROCEDURE
2929	13JBP - FACILITY INPATIENT JOINT BILATERAL PROCEDURES
2930	14AGE - INPATIENT INVALID AGE
2931	15MSEX - INPATIENT INVALID GENDER
2932	15SEX - INPATIENT INVALID GENDER
2933	16DSC - INVALID PATIENT STATUS CODE
2934	16MDSC - MISSING PATIENT STATUS CODE
2935	17LCP - INPATIENT LIMITED COVERAGE PROCEDURE
2936	17VLCP - INPATIENT LIMITED COVERAGE PROCEDURE
2937	17ZLCP - INPATIENT LIMITED COVERAGE PROCEDURE
2938	18OWPP - FACILITY INPATIENT WRONG PROCEDURE PERFORMED FOR OTHER DIAGNOSIS
2939	18PWPP - FACILITY INPATIENT WRONG PROCEDURE PERFORMED FOR PRINCIPAL DIAGNOSIS
2940	19LOS - FACILITY INPATIENT PROCEDURE INCONSISTENT WITH LENGTH OF STAY
2941	ABM1 - CONDITIONALLY BILATERAL
2942	ABM2 - INHERENTLY BILATERAL
2943	ABM3 - INDEPENDENTLY BILATERAL
2944	ABM9 - NOT BILATERAL
2945	ACTF - MISSING OR INVALID ACCOUNT ID
2946	APV1 - HCPCS CODE IS NOT VALID
2947	APV2 - HCPCS CODE IS NOT VALID FOR SERVICE DATE
2948	BDSF - MISSING OR INVALID DATE OF SERVICE
2949	BPRF - FACILTY BILATERAL PROCEDURE
2950	CCA - INVALID CONDITION CODE
2951	CCAF - INVALID CONDITION CODE
2952	CMF1 - AN APPROPRIATE MODIFIER ON CODE 1 OR CODE 2 MAY AFFECT THIS EDIT
2953	DADI - ADMIT DX INVALID
2954	DADI1 - NOT FOUND ON TABLE OF VALID ICD-9-CM CODES
2955	DADI2 - INVALID CODE, UNNECESSARY 4TH/5TH DIGIT
2956	DADI3 - INVALID CODE MISSING 4TH/5TH DIGIT
2957	DADI4 - CODE INVALID; FOUND ON ICD-9-CM TABLE, BUT NOT VALID FOR PATIENT’S ADMISSION/ DISCHARGE DATE
2958	DADI5 - INVALID CODE FOR DATES, UNNECESSARY 4TH/5TH DIGIT
2959	DADI6 - INVALID CODE FOR DATES, MISSING 4TH/5TH DIGIT
2960	DASC1 - DIAGNOSIS - AGE CONFLICT
2961	DASC2 - DIAGNOSIS - SEX CONFLICT
2962	DASC3 - DIAGNOSIS - AGE/SEX CONFLICT
2963	DCMF - ICD-10 TO ICD-9 DIAGNOSIS COMPARISON
2964	DDAS1 - ADMIT DIAGNOSIS AGE CONFLICT
2965	DDAS2 - ADMIT DIAGNOSIS SEX CONFLICT
2966	DDAS3 - ADMIT DIAGNOSIS AGE/SEX CONFLICT
2967	DDPD - DIAGNOSIS IS A DUPLICATE OF THE PRINCIPAL DIAGNOSIS
2968	DDSD - DIAGNOSIS IS A DUPLICATE OF ANOTHER SECONDARY DIAGNOSIS ON THIS CLAIM
2969	DDSP - ADMIT DX SUGGESTS MEDICARE SECONDARY PAYER
2970	DIA - INVALID PATIENT AGE
2971	DIBW - INVALID BIRTHWEIGHT
2972	DID - DIAGNOSIS - INVALID DIAGNOSIS
2973	DID1 - NOT FOUND ON TABLE OF VALID ICD-9-CM CODES
2974	DID2 - UNNECESSARY 4TH/5TH DIGIT
2975	DID3 - MISSING 4TH/5TH DIGIT
2976	DID4 - FOUND ON ICD-9-CM TABLE, BUT NOT VALID FOR PATIENT’S ADMISSION/DISCHARGE DATE
2977	DID5 - UNNECESSARY 4TH/5TH DIGIT FOR PATIENT’S ADMISSION/DISCHARGE DATE
2978	DID6 - MISSING 4TH/5TH DIGIT FOR PATIENT’S ADMISSION/DISCHARGE DATE
2979	DIDS - INVALID DISCHARGE STATUS
2980	DIS - INVALID PATIENT SEX
2981	DLPF - DUPLICATE LINE EDIT
2982	DMBP - CLAIM CONTAINS MULTIPLE BILATERAL PROCEDURES
2983	DMSP - DIAGNOSIS SUGGESTS MEDICARE SECONDARY PAYER
2984	DNSP - ALL OR PROCEDURES ON THIS CLAIM ARE NON-SPECIFIC
2985	DOBF - MISSING OR INVALID DATE OF BIRTH
2986	DPBC - PROCEDURE - BILATERAL CODE OR PROPOSED ALTERNATE CLOSED BIOPSY CODE. DO NOT RETURN SEPARATELY, INCLU
2987	DPCB - ALTERNATE CLOSED BIOPSY CODE
2988	DPDI1 - PRINCIPAL DIAGNOSIS INVALID - ‘E’ CODE CANNOT BE USED AS PRINCIPAL DIAGNOSIS
2989	DPDI2 - PRINCIPAL DIAGNOSIS INVALID - MANIFESTATION CODE CANNOT BE USED AS PRINCIPAL DIAGNOSIS
2990	DPDI3 - PRINCIPAL DIAGNOSIS INVALID - NON-SPECIFIC CODE CANNOT BE USED AS PRINCIPAL DIAGNOSIS
2991	DPDI4 - PRINCIPAL DIAGNOSIS INVALID – PRINCIPAL DIAGNOSIS INDICATES QUESTIONABLE ADMISSION
2992	DPDI5 - PRINCIPAL DIAGNOSIS INVALID - UNACCEPTABLE PRINCIPAL DIAGNOSIS
2993	DPDI6 - PRINCIPAL DIAGNOSIS INVALID - UNACCEPTABLE PRINCIPAL DIAGNOSIS WITHOUT REQUIRED SECONDARY DIAGNOSIS
2994	DPDS - PRINCIPLE DX SUGGESTS SURGERY BUT NO O.R. PROCEDURES ON CLAIM.
2995	DPIP - PROCEDURE - INVALID PROCEDURE
2996	DPIP1 - NOT FOUND ON TABLE OF VALID ICD-9-CM CODES
2997	DPIP2 - UNNECESSARY 4TH DIGIT
2998	DPIP3 - MISSING 4TH DIGIT
2999	DPIP4 - FOUND ON ICD-9-CM TABLE, BUT NOT VALID FOR PATIENT’S ADMISSION/DISCHARGE DATE
3000	DPIP5 - UNNECESSARY 4TH DIGIT FOR PATIENT’S ADMISSION/DISCHARGE DATE
3001	DPIP6 - MISSING 4TH DIGIT FOR PATIENT’S ADMISSION/DISCHARGE DATE
3002	DPNC1 - PROCEDURE NOT COVERED BY MEDICARE

3003	DPNC2 - OPEN BIOPSY CODE
3004	DPNC3 - LIMITED COVERAGE PROCEDURE
3005	DPSC - PROCEDURE-SEX CONFLICT
3006	DUPF - DUPLICATE CLAIM
3007	DUPFI - DUPLICATE INPATIENT CLAIM
3008	DUPIF - DUPLICATE INPATIENT CLAIM
3009	DUPOF - DUPLICATE OUPATIENT CLAIM
3010	DXE1 - E CODE CANNOT BE SUBMITTED AS ADMIT DIAGNOSIS
3011	DXE2 - MANIFESTATION CODE CANNOT BE SUBMITTED AS ADMIT DIAGNOSIS
3012	FTD - MISSING OR INVALID FROM THROUGH DATE
3013	FTDF - MISSING OR INVALID FROM (ADMISSION) DATE OR THRU (DISCHARGE) DATE
3014	GRPF - RETAIN PROCEDURE CODE PER TRANSFER RELATIONSHIP AND GROUPER ID
3015	GRPHF - RETAIN HISTORY PROCEDURE CODE PER TRANSFER RELATIONSHIP AND GROUPER ID
3016	HACAF - INPATIENT ADMISSION HOSPITAL ACQUIRED CONDITION
3017	HACF - INPATIENT PRINCIPAL HOSPITAL ACQUIRED CONDITION
3018	HACNAF - NON-EXEMPT ADMISSION DIAGNOSIS CODE
3019	HACNF - NON-EXEMPT PRINCIPAL DIAGNOSIS CODE
3020	HACNOF - NON-EXEMPT OTHER DIAGNOSIS CODE
3021	HACOF - INPATIENT OTHER HOSPITAL ACQUIRED CONDITION
3022	ICMF - THE PRIMARY DIAGNOSIS IS MISSING
3023	IPA - INVALID ICD-9 PROCEDURE ARRAY
3024	LAE1 - CODE VIOLATES AGE CONSTRAINTS
3025	LAE2 - THERE ARE AGE REQUIREMENTS FOR THE CODE BUT CLAIM HAS NO AGE
3026	LCAG - LCD PROCEDURE NOT TYPICAL WITH PATIENT AGE
3027	LCC - LCD CODE TO CODE MISSING OR INVALID
3028	LCDY - LCD DENY
3029	LCFR - LCD PROCEDURE FREQUENCY EXCEEDED
3030	LCG - LCD INAPPROPRIATE GENDER
3031	LCI- DIAGNOSIS REQUIREMENTS NOT MET PER MEDICARE LCD
3032	LCM - LCD MISSING REQUIRED MODIFIER
3033	LCON - LCD MISSING OR INVALID CONDITION CODE(S)
3034	LCP - LCD MISSING PRIMARY DIAGNOSIS CODE
3035	LCPF - LCD REQUIREMENTS MET
3036	LCRD - LCD REVIEW/REQUEST DOCUMENTATION
3037	LCS - LCD MISSING SECONDARY DIAGNOSIS CODE
3038	LCT - LCD MISSING TERTIARY DIAGNOSIS CODE
3039	LCV1 - HCPCS CODE IS NOT CURRENTLY VALID
3040	LCV2 - HCPCS CODE IS NOT VALID FOR SERVICE DATE
3041	LDDX01 - STATUTORY DENIED DIAGNOSIS CODE FOUND ON CLAIM
3042	LNAP1 - CODE IS MISSING AN APPROPRIATE ACCOMPANYING PROCEDURE
3043	LNC1 - HCPCS CODE IS NOT CURRENTLY COVERED BY MEDICARE
3044	LNC2 - HCPCS CODE IS NOT COVERED BY MEDICARE BASED ON STATUTE
3045	LND1 - CODE DOES NOT HAVE SUPPORTING DIAGNOSIS CODE
3046	LNSD1 - CODE IS MISSING AN APPROPRIATE SECONDARY DIAGNOSIS
3047	LRC - LCD MISSING OR INVALID REVENUE CODE
3048	LSE1 - CODE VIOLATES SEX CONSTRAINTS
3049	LSE2 - THERE ARE GENDER REQUIREMENTS FOR THIS SERVICE BUT PATIENT SEX IS MISSING OR INVALID
3050	LTOB - LCD INVALID TYPE OF BILL
3051	LVC - LCD MISSING OR INVALID VALUE CODE(S)
3052	MFXEF - FACILITY OUTPATIENT MAXIMUM FREQUENCY EXCEEDED
3053	MFXEHF - FACILITY OUTPATIENT MAXIMUM FREQUENCY EXCEEDED - HISTORY
3054	MFXF - FACILITY OUTPATIENT MAXIMUM FREQUENCY EXCEEDED
3055	MFXHF - FACILITY OUTPATIENT MAXIMUM FREQUENCY EXCEEDED - HISTORY
3056	MPMF - FACILITY OUTPATIENT NEVER EVENTS
3057	MPRF - MULTIPLE PROCEDURE REDUCTION
3058	MPRHF - BILL TYPE 085X WITH PROFESSIONAL REVENUE CODE 096X, 097X AND 098X, THERE MUST BE TWO OR MORE PROCEDURES THAT ARE SUBJECT TO MULTIPLE PROCEDURE DISCOUNTING FOR THIS RULE TO APPLY
3059	OCC - INVALID OCCURRENCE CODE
3060	OCCF - INVALID OCCURRENCE CODE
3061	OSC - INVALID OCCURRENCE SPAN CODE
3062	OSCF - INVALID OCCURRENCE SPAN CODE
3063	PATF - MISSING PATIENT ID
3064	PRVF - MISSING PROVIDER ID
3065	PSC - MISSING OR INVALID PATIENT STATUS CODE
3066	PSCF - THIS CLAIM HAS A MISSING OR INVALID PATIENT DISCHARGE STATUS CODE
3067	PSXF - MISSING OR INVALID PATIENT GENDER
3068	REBF - DENY PROCEDURE CODE PER TRANSFER RELATIONSHIP AND GROUPER ID
3069	REBHF - DENY HISTORY PROCEDURE CODE PER TRANSFER RELATIONSHIP AND GROUPER ID
3070	REV - MISSING OR INVALID REVENUE CODE
3071	REVF - THE CLAIM LINE HAS A MISSING OR INVALID REVENUE CODE
3072	SMUEF - MEDICAID INSTITUTIONAL MEDICALLY UNLIKELY EDITS
3073	SOA - INVALID SOURCE OF ADMISSION
3074	SOAF - INVALID SOURCE OF ADMISSION CODE
3075	SUNF - BUNDLED - MEDICAID INSTITUTIONAL NCCI EDITS
3076	SUNHF - MEDICAID INSTITUTIONAL NATIONAL CORRECT CODING INITIATIVE EDITS IN HISTORY
3077	TFEF - MEDICARE TIMELY FILING EXCEEDED
3078	TOA - INVALID TYPE OF ADMISSION
3079	TOAF - INVALID TYPE OF ADMISSION CODE
3080	TOB - MISSING OR INVALID TYPE OF BILL
3081	TOBF - MISSING OR INVALID TYPE OF BILL
3082	TPRDF - TERMINATED PROCEDURE REDUCTION
3083	TPRF - TERMINATED PROCEDURE REDUCTION
3084	TRAF - ADD PROCEDURE CODE TO THE CURRENT CLAIM PER TRANSFER RELATIONSHIP AND GROUPER ID
3085	VAL - INVALID VALUE CODE
3086	VALF - INVALID VALUE CODE
3097	006IPC - INVALID HCPCS CODE FOR THE SERVICE DATE ON THE CLAIM LINE
3101	008CSX - PER CMS INTEGRATED OCE (IOCE) SPECIFICATIONS, THE HCPCS CODE, INCLUDES A GENDER DESIGNATION AND THE GENDER SUBMITTED ON THE CLAIM DOES NOT MATCH

3105	017IBP - HCPCS CODE IS INHERENTLY BILATERAL AND SHOULD NOT BE BILLED MORE THAN ONCE FOR THE SAME DATE OF SERVICE
3108	018INP - PER CMS, PROCEDURE CODE IS DESIGNATED AS AN INPATIENT ONLY PROCEDURE PERFORMED IN AN OUTPATIENT HOSPITAL SETTING
3109	020CCP - PROCEDURE CODE IS CONSIDERED TO BE A COMPONENT OF THE COMPREHENSIVE CODE. A MODIFIER WILL NOT OVERRIDE THIS EDIT
3110	020HCCP - HISTORY PROCEDURE CODE ON HISTORY CLAIM ON HISTORY LINE IS CONSIDERED TO BE A COMPONENT OF THE COMPREHENSIVE PROCEDURE CODE ON THE CURRENT LINE AND THE HISTORY LINE MAY BE DENIED.
3111	021EMO - BUNDLED - MEDICAL VISIT IS ON THE SAME DAY AS A PROCEDURE WITH A STATUS INDICATOR OF T OR S
3112	021HEMO - MEDICAL VISIT IS ON THE SAME DAY AS A PROCEDURE WITH A STATUS INDICATOR OF T OR S WITHOUT MODIFIER 25
3113	022IMO - THE MODIFIER CODE IS EITHER NOT A VALID CODE OR NOT VALID FOR THE FROM DATE OF SERVICE ON THE CLAIM
3116	037TBP - TERMINATED PROCEDURES SHOULD NOT BE BILLED WITH MULTIPLE UNITS OF SERVICE
3117	038IIP - INCONSISTENCY BETWEEN IMPLANTED DEVICE AND IMPLANTATION PROCEDURE
3118	03DDC - THE OTHER DIAGNOSIS CODE IS A DUPLICATE OF THE PRINCIPAL DIAGNOSIS CODE
3119	040CCO - PROCEDURE CODE IS CONSIDERED TO BE A COMPONENT OF THE COMPREHENSIVE CODE AND THIS LINE SHOULD BE DENIED. REVIEW DOCUMENTATION TO DETERMINE IF A MODIFIER IS APPROPRIATE
3120	040HCCO - HISTORY PROCEDURE CODE ON HISTORY CLAIM ON HISTORY LINE IS CONSIDERED TO BE A COMPONENT OF THE COMPREHENSIVE PROCEDURE CODE AND THE HISTORY LINE MAY BE DENIED. REVIEW THE MEDICAL RECORD TO DETERMINE IF AN APPROPRIATE MODIFIER SHOULD BE ASSIGNED
3122	041IRC - INVALID OR MISSING REVENUE CODE
3123	042MMV - MULTIPLE MEDICAL VISITS ON SAME DAY, SAME REVENUE CODE WITHOUT CONDITION CODE GO
3124	043TBP - THE BLOOD ADMINISTRATION CODE REQUIRES THAT A HCPCS BLOOD PRODUCT CODE BE PRESENT ON THE CLAIM
3125	044ORC - OBSERVATION ROOM REVENUE CODE WITHOUT SPECIFICATION OF APPROPRIATE OBSERVATION ROOM SERVICE
3126	045SNA - PER CMS, PROCEDURE CODE IS DESIGNATED AS AN INPATIENT SEPARATE PROCEDURE PERFORMED IN AN OUTPATIENT HOSPITAL SETTING
3127	048RRH - CLAIM LINE REVENUE CODE REQUIRES SUBMISSION OF A HCPCS CODE
3128	049SIP - ANCILLARY SERVICE BILLED ON THE SAME DAY AS AN INPATIENT ONLY PROCEDURE
3129	053OTB - OBSERVATION HCPCS CODES CAN ONLY BE BILLED WITH A BILL TYPE OF 013X OR 085X
3130	055NRS - NOT REPORTABLE FOR THIS SITE OF SERVICE
3133	057OES - PER CMS GUIDELINES THERE IS NO SPECIFIED E/M OR CRITICAL CARE VISIT THE DAY OF OR THE DAY PRECEDING THE OBSERVATION HCPCS CODE G0378, THEREFORE THE APC COMPOSITE REQUIREMENT IS NOT MET
3135	061SBD - CODE CAN ONLY BE BILLED TO THE DME REGIONAL CARRIER
3136	062CNR - HCPCS CODE IS NOT RECOGNIZED BY OPPS
3137	063OPH - OCCUPATIONAL THERAPY CAN ONLY BE BILLED ON PARTIAL HOSPITALIZATION CLAIMS
3138	066CMP - CODE REQUIRES MANUAL PRICING
3139	06PMDC - MANIFESTATION CODES CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS
3140	071CDC - CLAIM LACKS REQUIRED DEVICE CODE
3141	072SNB - SERVICE IS NOT BILLABLE TO AN FI OR MAC
3142	073IBP - INCORRECT BILLING OF BLOOD AND BLOOD PRODUCTS
3143	074UBP - UNITS GREATER THAN ONE FOR BILATERAL PROCEDURE BILLED WITH MODIFIER 50
3144	075IBM - MODIFIER FB OR FC SHOULD NOT BE REPORTED ON A CLAIM WITH A DEVICE IMPLANTATION PROCEDURE
3145	075IBMA - INCORRECT BILLING OF MODIFIER FB AND/OR FC
3146	077DPC - CLAIM LACKS ALLOWED ACCOMPANYING PROCEDURE CODE FOR DEVICE
3147	078DNM - CLAIM LACKS REQUIRED HCPCS LEVEL II CODE FOR THE RADIOPHARMACEUTICAL DRUG
3148	079IRC - REVENUE CODES 381 AND 382 CAN ONLY BE USED WHEN BILLING FOR PACKED RED BLOOD CELLS (381) AND WHOLE BLOOD (382)
3149	080MHA - HCPCS CODE IS NOT APPROVED FOR A PARTIAL HOSPITALIZATION CLAIM
3150	081MHP - APPROVED PARTIAL HOSPITALIZATION MENTAL HEALTH SERVICES SUBMITTED WITH BILL TYPE 12X OR 13X MUST HAVE CONDITION CODE 41 ON THE CLAIM
3151	082CET - THE CHARGED AMOUNT FOR HCPCS CODE C9898 CANNOT EXCEED $1.01
3152	085OSD - HCPCS CODE C1840 MUST BE SUBMITTED WITH PROCEDURE CODE C9732 IF DATE OF SERVICE IS ON OR BETWEEN JANUARY 1, 2012 TO JUNE 30, 2012 OR 0308T IF THE DATE OF SERVICE IS ON OR AFTER JULY 1, 2012 ON THE SAME DATE OF SERVICE
3153	086PMDC - MANIFESTATION CODES CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS
3154	087SSR - SKIN SUBSTITUTE APPLICATION PROCEDURE CODE MUST BE SUBMITTED WITH THE APPROPRIATE SKIN SUBSTITUTE PRODUCT PROCEDURE CODE ON THE SAME DATE OF SERVICE
3155	087SSRA - SKIN SUBSTITUTE APPLICATION PROCEDURE CODE MUST BE SUBMITTED WITH THE APPROPRIATE SKIN SUBSTITUTE PRODUCT PROCEDURE CODE ON THE SAME DATE OF SERVICE
3156	088PHC - A FQHC CLAIM MUST CONTAIN A REQUIRED FQHC PAYMENT CODE
3157	089QVC - A FQHC CLAIM REQUIRES BOTH THE FQHC PAYMENT CODE AND A QUALIFYING VISIT CODE
3158	090REV - THE FQHC PAYMENT CODE REQUIRES SPECIFIC REVENUE CODES
3159	091NCS - ITEMS OR SERVICES ARE NOT COVERED UNDER THE FQHC PPS
3160	09OUAD - DIAGNOSIS CODE IS UNACCEPTABLE AS A PRINCIPAL DIAGNOSIS UNLESS A REQUIRED SECONDARY DIAGNOSIS IS INCLUDED ON THE CLAIM
3161	09PUAD - DIAGNOSIS CODE IS UNACCEPTABLE AS A PRINCIPAL DIAGNOSIS
3162	100AEC - AN EXTERNAL CAUSE CODE CANNOT BE USED AS THE ADMIT DIAGNOSIS CODE
3163	100PEC - AN EXTERNAL CAUSE CODE CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS CODE
3164	11NCP - PROCEDURE CODE IS NON-COVERED
3165	17IBP - THE HCPCS CODE ON THIS LINE WAS ALSO BILLED ON HISTORY CLAIM ON HISTORY LINE FOR THE SAME DATE OF SERVICE. THIS CODE IS INHERENTLY BILATERAL AND SHOULD NOT BE BILLED MORE THAN ONCE FOR THE SAME DATE OF SERVICE
3166	17LCP - PROCEDURE CODE(S) IS A LIMITED COVERAGE CODE
3167	18OWPP - THE OTHER DIAGNOSIS CODE INDICATES THAT A WRONG PROCEDURE WAS PERFORMED
3168	18PWPP - THE PRINCIPAL DIAGNOSIS CODE INDICATES THAT A WRONG PROCEDURE WAS PERFORMED
3169	26TC - GLOBAL PROCEDURE PREVIOUSLY SUBMITTED FOR MEMBER AND DOS
3170	26TCH - THE PROCEDURE CODE HAS BEEN SUBMITTED IN HISTORY WITH THE MODIFIERS 26 OR TC
3171	37TBP - TERMINATED PROCEDURES SHOULD NOT BE BILLED AS BILATERAL
3172	42MMV - MULTIPLE MEDICAL VISITS BILLED ON THE SAME DAY FOR THE SAME REVENUE CODE. E/M VISIT FOUND ON HISTORY CLAIM ON HISTORY LINE

3173	85OSDA - HCPCS CODE C1840 MUST BE SUBMITTED WITH PROCEDURE CODE C9732 IF DATE OF SERVICE IS ON OR BETWEEN JANUARY 1, 2012 TO JUNE 30, 2012 OR 0308T IF THE DATE OF SERVICE IS ON OR AFTER JULY 1, 2012 ON THE SAME DATE OF SERVICE
3174	ADDF - ALWAYS ESRD RELATED DRUGS SUBJECT TO CONSOLIDATED BILLING CANNOT BE REPORTED SEPARATELY
3175	AHCF - AMBULANCE SERVICE HCPCS CODE REQUIRES AN AMBULANCE MILEAGE HCPCS CODE
3176	ANRF - CODE J0882 MUST BE SUBMITTED WITH REVENUE CODE 0636
3177	APP - PROCEDURE CODE 44970 SHOULD NOT BE REPORTED FOR A LAPAROSCOPIC APPENDECTOMY PERFORMED IN CONJUNCTION WITH PROCEDURE CODE THAT HAS BEEN REPORTED
3178	APPH - PROCEDURE CODE 44970 FOUND IN HISTORY AND SHOULD NOT BE REPORTED FOR A LAPAROSCOPIC APPENDECTOMY PERFORMED IN CONJUNCTION WITH PROCEDURE CODE
3179	APRF - A 10% REDUCTION SHOULD BE APPLIED TO HCPCS CODE WHEN IT IS FOR A NON-EMERGENCY BLS TRANSPORT TO AND FROM A RENAL DIALYSIS FACILITY FOR AN ESRD PATIENT
3180	ARCF - AMBULANCE HCPCS CODES REQUIRE AN APPROPRIATE REVENUE CODE
3181	ARMF - INVALID OR MISSING REQUIRED AMBULANCE MODIFIER(S)
3182	ASRF - ASSISTANT AT SURGERY MODIFIERS ARE ONLY PAYABLE BY MEDICARE IN METHOD II CRITICAL ACCESS HOSPITALS (CAHS)
3183	ATSF - HOSPITALS MUST ALWAYS REPORT A THERAPY MODIFIER FOR ALWAYS THERAPY PROCEDURE CODES
3184	AUSF - PER MEDICARE GUIDELINES, THE MAXIMUM ALLOWED UNITS FOR AMBULANCE PROCEDURE CODES IS 1. THE UNITS FOR PROCEDURE CODE EXCEED THE ALLOWED UNITS
3185	AWVC - THE FREQUENCY FOR HCPCS CODE HAS BEEN EXCEEDED, PER CMS THE LIMIT IS ONCE IN A LIFETIME
3186	AWVFF - PER MEDICARE, THIS SERVICE IS ONLY COVERED ONCE A LIFETIME
3187	AWVIPC - SERVICE OCCURRED WITHIN A YEAR OF AN INITIAL PREVENTIVE PHYSICAL EXAM (IPPE) ON A PREVIOUS PROFESSIONAL CLAIM IN HISTORY
3188	AWVIPF - SERVICE OCCURRED WITHIN A YEAR OF AN INITIAL PREVENTIVE PHYSICAL EXAM
3189	AWVSC - SERVICE OCCURRED WITHIN A YEAR OF LAST COVERED ANNUAL WELLNESS VISIT ON A PREVIOUS PROFESSIONAL CLAIM IN HISTORY
3190	AWVSF - SERVICE OCCURRED WITHIN A YEAR OF LAST COVERED ANNUAL WELLNESS VISIT
3191	BMBNA - HCPCS CODE C1830 REQUIRES AN APPROPRIATE PROCEDURE
3192	BMBNPA - PROCEDURE CODE REQUIRES PASS-THROUGH DEVICE CODE C1830
3193	BTRF - PASS-THROUGH CATEGORY HCPCS CODE C1886 MUST BE SUBMITTED WITH THE PROCEDURE CODE FOR BRONCHIAL THERMOPLASTY ON THE SAME DATE OF SERVICE
3194	CAG1 - PROCEDURE CODE 99100 IS NOT TYPICAL FOR AGE OF PATIENT
3196	CCDF - CONDITION CODES H3, H4 AND H5 MUST BE SUBMITTED ON END STAGE RENAL DISEASE CLAIMS
3197	CCTF - PER CMS, COMPOSITE APCS PROVIDE A SINGLE PAYMENT FOR THE FAMILY OF IMAGING PROCEDURES FOR COMPUTED TOMOGRAPHY AND TOMOGRAPHIC ANGIOGRAPHY. CMS MAKES A SINGLE PAYMENT FOR ALL OF THE CODES AS A WHOLE, RATHER THAN PAYING INDIVIDUALLY FOR EACH CODE
3198	CDL - PROCEDURE CODE HAS BEEN DELETED AS OF
3199	CDLA - PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED OR THE DATE OF SERVICE BILLED
3200	CFAH - PROCEDURE CODE 22554 IS REPORTED BY A DIFFERENT PROVIDER. DOCUMENTATION INDICATING THAT THE SERVICE WAS PROVIDED ON A SEPARATE LEVEL MAY BE NECESSARY
3201	CFDH - PROCEDURE CODE 63075 IS REPORTED BY A DIFFERENT PROVIDER. DOCUMENTATION INDICATING THAT THE SERVICE WAS PROVIDED ON A SEPARATE LEVEL MAY BE NECESSARY
3202	CMRF - PER CMS, COMPOSITE APCS PROVIDE A SINGLE PAYMENT FOR THE FAMILY OF IMAGING PROCEDURES FOR MAGNETIC RESONANCE IMAGING AND ANGIOGRAPHY. CMS MAKES A SINGLE PAYMENT FOR ALL OF THE CODES AS A WHOLE, RATHER THAN PAYING INDIVIDUALLY FOR EACH CODE
3203	CPO - ONLY ONE INDIVIDUAL MAY REPORT A SINGLE CARE PLAN OVERSIGHT CPT CODE PER PATIENT IN THE SAME MONTH
3204	CPO1 - PROCEDURE CODE 99091 CANNOT BE REPORTED WITHIN 30 DAYS OF THE CARE PLAN OVERSIGHT CODE REPORTED
3205	CPO1H - PROCEDURE CODE 99091 FOUND IN HISTORY IS INCLUDED IN CARE PLAN OVERSIGHT SERVICE , WHEN REPORTED IN THE SAME 30 DAY PERIOD
3206	CRFDF - THE CAPPED RENTAL FREQUENCY OF ONCE PER MONTH FOR 13 MONTHS HAS BEEN EXCEEDED FOR THIS CODE
3207	CRTDA - INVALID BILLING OF CARDIAC RESYNCHRONIZATION THERAPY (CRT-D) IN AN AMBULATORY SURGICAL CENTER (ASC) SETTING
3208	CSX - PROCEDURE CODE IS NOT TYPICALLY PERFORMED FOR A PATIENT WHOSE GENDER IS
3209	CSXA - PROCEDURE NOT PAYABLE FOR GENDER
3210	CTNF - MANDATORY CLINICAL TRIAL REGISTRY NUMBER IS MISSING
3211	CTRF - REVENUE CODE IS INAPPROPRIATE FOR TOB 075X
3212	CUSF - PER CMS, COMPOSITE APCS PROVIDE A SINGLE PAYMENT FOR THE FAMILY OF IMAGING PROCEDURES FOR ULTRASOUND. CMS MAKES A SINGLE PAYMENT FOR ALL OF THE CODES AS A WHOLE, RATHER THAN PAYING INDIVIDUALLY FOR EACH CODE
3213	DARBF - PER MEDICARES MEDICALLY UNLIKELY EDITS, THE UNITS FOR DARBEPOETIN ALFA EXCEED THE ALLOWED UNITS
3214	DCC1F - ONLY ONE OF THE FOLLOWING CONDITION CODES 70, 71, 72, 73, 74, 75, OR 76 CAN BE SUBMITTED ON AN ESRD CLAIM
3215	DCCF - PER CMS GUIDELINES, ONE CONDITION CODE 59, 71, 72, 73, 74, 76 OR 80 MUST BE PRESENT ON END STAGE RENAL DISEASE (ESRD) TYPE OF BILL 072X CLAIMS
3216	DIPA - MEDICARE DOES NOT PAY SEPARATELY FOR THIS SERVICE
3217	DLP - PROCEDURE CODE IS A POSSIBLE DUPLICATE OF THE SAME PROCEDURE CODE FOUND PERFORMED BY THE SAME PROVIDER ON THE SAME DAY
3218	DLPA - PROCEDURE CODE IS A POSSIBLE DUPLICATE OF THE SAME PROCEDURE CODE FOUND REPORTED BY THE SAME PROVIDER USING ANATOMIC MODIFIERS
3219	DLPB - PROCEDURE CODE IS A POSSIBLE DUPLICATE OF THE SAME PROCEDURE CODE FOUND REPORTED BY THE SAME PROVIDER USING LT OR RT MODIFIER
3220	DLPG - PROCEDURE CODE IS A POSSIBLE DUPLICATE OF THE SAME PROCEDURE CODE FOUND REPORTED BY THE SAME PROVIDER USING G MODIFIERS
3221	DRCF - ONLY REVENUE CODES FOR PART B INPATIENT SERVICES CAN BE SUBMITTED ON TOB 012X
3222	DSPHF - PER MEDICARE GUIDELINES, THE PATIENT DISCHARGE STATUS CODE MUST BE 30 [STILL PATIENT] WHEN THE FREQUENCY DIGIT IS THE TYPE OF BILL 2 [INTERIM- FIRST CLAIM] OR THE FREQUENCY DIGIT IS THE TYPE OF BILL 3 [INTERIM- CONTINUING CLAIM]
3223	ECTF - INPATIENT PSYCHIATRIC FACILITY REQUIRES ICD PROCEDURE FOR ELECTROCONVULSIVE THERAPY (ECT)
3224	EPRF - CODE Q4081 MUST BE SUBMITTED WITH REVENUE CODE 0634 OR 0635

3225	ESR1 - IT IS INAPPROPRIATE TO SUBMIT AN ESRD RELATED SERVICE CODE (4 OR MORE FACE-TO-FACE VISITS BASED ON PATIENTS AGE) MORE THAN ONCE PER MONTH
3226	ESR2 - IT IS INAPPROPRIATE TO SUBMIT AN ESRD RELATED SERVICE CODE (2-3 FACE-TO-FACE VISITS BASED ON PATIENTS AGE) MORE THAN ONCE PER MONTH
3227	ESR3 -FREQUENCY LIMIT EXCEEDED. ESRD RELATED SERVICE CODE (1 FACE-TO-FACE VISIT BASED ON PATIENTS AGE) IS ALLOWED ONCE PER MONTH
3228	FCRP - PROCEDURE CODE FOUND ON CLAIM IS A FACILITY SERVICE CODE. THIS SERVICE IS NOT TO BE REPORTED ON A PROFESSIONAL CLAIM
3229	FTDF - THE STATEMENT COVERS PERIOD FROM DATE IS MISSING
3230	GFP1 - PROCEDURE CODE IS WITHIN THE GLOBAL PERIOD OF A SURGICAL PROCEDURE CODE PERFORMED BY THE SAME PROVIDER
3232	HACNF - THE PRINCIPAL DIAGNOSIS CODE REQUIRES A NON-EXEMPT POA INDICATOR
3233	HACNOF - THE OTHER DIAGNOSIS CODE REQUIRES A NON-EXEMPT POA INDICATOR
3234	HBS - A HYSTERECTOMY MUST BE REPORTED BY SPECIALTY GENERAL SURGEON (2), OBSTETRICS/GYNECOLOGY (16), UROLOGY (34), SURGICAL ONCOLOGY (91) OR GYNECOLOGICAL ONCOLOGY (98)
3235	HDCF - REVENUE CODE 082X REQUIRES HCPCS CODE 90999
3236	HHRHF - HOME HEALTH SERVICES MUST BE REPORTED WITH AN APPROPRIATE HOME HEALTH AIDE REVENUE CODE
3237	HHROF - HOME HEALTH SERVICES MUST BE REPORTED WITH AN APPROPRIATE HOME HEALTH OCCUPATIONAL THERAPY REVENUE CODE
3238	HHRPF - HOME HEALTH SERVICES MUST BE REPORTED WITH AN APPROPRIATE HOME HEALTH PHYSICAL THERAPY REVENUE CODE
3239	HHRSF - HOME HEALTH SERVICES MUST BE REPORTED WITH AN APPROPRIATE HOME HEALTH SKILLED NURSING REVENUE CODES
3240	HHRSPF - HOME HEALTH SERVICES MUST BE REPORTED WITH AN APPROPRIATE HOME HEALTH SPEECH LANGUAGE PATHOLOGY REVENUE CODE
3241	HHRSSF - HOME HEALTH SERVICES MUST BE REPORTED WITH AN APPROPRIATE HOME HEALTH SOCIAL SERVICE REVENUE CODE
3242	HHVCF - VALUE CODE 61 MUST BE REPORTED ON ALL HOME HEALTH PPS AND RAP CLAIMS TO REPORT LOCATION
3243	HLCF - HOSPICE LOCATION CODES MUST BE SUBMITTED ON REVENUE CODES 0651, 0652, 0655 OR 0656; 0652 MUST NOT EXCEED 96 UNITS
3244	HPE1F - HOSPICE REVENUE CODE 0657 MUST NOT BE SUBMITTED WITH ANY OTHER REVENUE CODE ON THE SAME CLAIM
3245	HPEF - CODE G0337 MUST BE SUBMITTED WITH REVENUE CODE 0657 ONLY ON THE CLAIM WITH A HOSPICE TYPE OF BILL AND NO OTHER REVENUE CODE MAY BE PRESENT
3246	HPEF - CODE G0337 MUST BE SUBMITTED WITH REVENUE CODE 0657 ONLY ON THE CLAIM WITH A HOSPICE TYPE OF BILL AND NO OTHER REVENUE CODE MAY BE PRESENT
3247	HPL1F - HOSPICE RESPITE CARE MUST BE SUBMITTED WITH OCCURRENCE CODE M2
3248	HPLF - PER CMS, HOSPICE RESPITE CARE SHOULD NOT BE REPORTED FOR MORE THAN 5 DAYS AT A TIME
3249	HPS - A HYSTERECTOMY FOLLOWING SURGICAL TREATMENT OF AN ECTOPIC PREGNANCY OR A C/SECTION DELIVERY MAY NOT BE REPORTED BY ANY SPECIALTY OTHER THAN OBSTETRICS/GYNECOLOGY (16)
3250	HRGF - HOSPICE REVENUE CODES MUST BE SUBMITTED WITH AN APPROPRIATE HOSPICE HCPCS CODE
3251	HRVCF - REVENUE CODE MUST BE SUBMITTED WITH APPROPRIATE VALUE CODE
3252	HSBF - PER MEDICARE GUIDELINES, ONLY ONE HOSPICE CLAIM CAN BE SUBMITTED PER MONTH AND THE STATEMENT DATE RANGE CANNOT BE GREATER THAN 1 MONTH
3253	IAGA - DIAGNOSIS NOT TYPICAL FOR AGE
3254	ICMF - THE PRINCIPAL DIAGNOSIS CODE IS MISSING
3255	IDDMF - THE DISCHARGE DATE IS MISSING
3256	IM27F - MODIFIER 27 IS NOT APPROPRIATE AS ANOTHER LINE WITH AN EVALUATION AND MANAGEMENT CODE IS NOT FOUND IN HISTORY
3257	INJ - SEPARATE REPORTING IS ALLOWED FOR THE SUPPLY CODE OF INJECTABLE MATERIALS PROVIDED IN POS WHEN INJECTION PROCEDURE IS REPORTED
3258	INJ1 - SEPARATE REPORTING IS ALLOWED FOR THE INJECTION PROCEDURE PERFORMED IN POS WHEN SUPPLY CODE OF INJECTABLE MATERIALS IS REPORTED
3259	IOTPA - PROCEDURE CODE MUST BE SUBMITTED WITH PROCEDURE CODE C1840 ON THE SAME DATE OF SERVICE
3260	IPRF - A PRINCIPAL PROCEDURE CODE IS REQUIRED WHEN A PROCEDURE CODE IS FOUND IN THE OTHER PROCEDURE CODE FIELD
3261	ISRPF - IMPLANTABLE SUPPLY HCPCS CODE REQUIRES AN ASSOCIATED SURGICAL PROCEDURE CODE
3262	ISX - DIAGNOSIS CODE IS NOT ALLOWED FOR A PATIENT GENDER
3263	ISXA - DIAGNOSIS NOT ALLOWED FOR PATIENT GENDER
3264	ITDF - CODE G0257 MUST BE SUBMITTED WITH TOB 013X OR 085X
3265	LOCQ1F - LOCATION CODES Q5001, Q5002 AND Q5009 MUST BE SUBMITTED WITH REVENUE CODES 042X, 043X, 044X, 055X, 056X OR 057X AND MUST BE REPORTED ON EVERY HOME HEALTH CLAIM
3266	LOCQ2F - HOME HEALTH CLAIMS CODES Q5001, Q5002 OR Q5009 MUST HAVE A MATCHING HOME HEALTH VISIT WITH SAME REVENUE CODE
3267	LOCQF - LOCATION CODE Q5001, Q5002 OR Q5009 MUST NOT BE REPORTED MORE THAN ONCE ON THE SAME CLAIM
3268	M27F - THIS PATIENT RECEIVED MULTIPLE EM VISITS ON THE SAME DATE OF SERVICE (DOS) AND MODIFIER 27 IS NOT APPENDED
3269	M50F - PER CMS GUIDELINES, HOSPITALS SHOULD REPORT BILATERAL SURGICAL PROCEDURES ON A SINGLE CLAIM LINE WITH MODIFIER 50 AND ONE (1) UNIT OF SERVICE. CLAIMS SUBMITTED WITH TWO LINES OR TWO UNITS AND ANATOMIC MODIFIERS WILL BE DENIED FOR INCORRECT CODING
3270	M52 - A PROCEDURE CODE HAS BEEN SUBMITTED WITH MODIFIER 52, REDUCED SERVICES. PER MEDICARE GUIDELINES, DOCUMENTATION IS REQUIRED. CLAIM PAYMENT MAY BE REDUCED
3271	M53 - PER MEDICARE GUIDELINES PROCEDURE CODE WHEN BILLED WITH MODIFIER 53 IS SUBJECT TO CARRIER MEDICAL REVIEW AND PRICED BY INDIVIDUAL CONSIDERATION
3272	M62 - MODIFIER 62 IS NOT PRESENT ON PROCEDURE CODE AND IS REPORTED BY A DIFFERENT PROVIDER
3273	M62DH - MODIFIER 62 IS PRESENT ON PROCEDURE CODE . THE SAME PROCEDURE CODE WITHOUT MODIFIER 62 APPENDED WAS PREVIOUSLY REPORTED BY A DIFFERENT PROVIDER
3274	M62R - PROCEDURE CODE REQUIRES MODIFIER 62
3275	MAR - PER MEDICARE GUIDELINES APPLY 10% REDUCTION TO CLAIM LINES CONTAINING HCPCS CODE A0425 AND A0428 WHEN BILLED WITH AN ORIGIN/DESTINATION MODIFIER THAT CONTAINS G OR J IN ANY POSITION
3276	MASF - MODIFIER 80, 81 OR 82 MUST ALSO BE BILLED IN CONJUNCTION WITH MODIFIER AS
3277	MAT - PER MEDICARE GUIDELINES PROCEDURE CODE REQUIRES MODIFIER GP, GO, OR GN
3278	MAWF - PER MEDICARE, THIS SERVICE IS COVERED ONCE IN A LIFETIME

3279	MAWP - FREQUENCY LIMIT EXCEEDED - SERVICE OCCURRED WITHIN A YEAR OF AN INITIAL PREVENTIVE PHYSICAL EXAM
3280	MAWS - SERVICE OCCURRED WITHIN A YEAR OF LAST COVERED ANNUAL WELLNESS VISIT
3281	MBC - PER CMS GUIDELINES, PAYMENT FOR PROCEDURE CODE IS ALWAYS BUNDLED INTO PAYMENT FOR OTHER SERVICES NOT SPECIFIED AND NO SEPARATE PAYMENT IS MADE
3282	MEPG - RETAIN PROCEDURE CODE 1. THE TRANSFER RELATIONSHIP IS 4. THE GROUPER ID IS 5
3283	MEYF - PER MEDICARE GUIDELINES, PAYMENT CANNOT BE MADE FOR A SERVICE OR ITEMS THAT DOES NOT HAVE A PHYSICIAN ORDER OR PRESCRIPTION
3284	MF30 - PROCEDURE CODE MAY NOT BE REPORTED MORE THAN ONCE IN A 30 DAY PERIOD
3285	MF90 - PROCEDURE CODE MAY NOT BE REPORTED MORE THAN ONCE IN A 90 DAY PERIOD
3286	MFDF - MAXIMUM FREQUENCY PER DAY HAS BEEN EXCEEDED
3287	MFLF - A DIAGNOSIS CODE(S), WHICH MEETS MEDICAL NECESSITY FOR PROCEDURE CODE IS MISSING
3288	MFP24 - PER MEDICARE GUIDELINES, THIS PROCEDURE CODE IS WITHIN THE GLOBAL PERIOD OF A PROCEDURE CODE FOUND IN HISTORY SUBMITTED BY THE SAME PROVIDER
3289	MFP24H - PER MEDICARE GUIDELINES, A PROCEDURE CODE EXISTS IN HISTORY WITH THE SAME DIAGNOSIS BY THE SAME PROVIDER AS THE SUBMITTED PROCEDURE CODE DURING THE GLOBAL PERIOD FOR THE SAME PATIENT
3290	MFSQ - MEDICARE PHYSICIAN FEE SCHEDULE STATUS INDICATOR Q CODE IS A NONPAYABLE FUNCTION-RELATED G-CODE AND IS USED FOR REQUIRED REPORTING PURPOSES ONLY
3291	MFX1 - THE MAXIMUM FREQUENCY FOR THE PROCEDURE CODE HAS BEEN EXCEEDED. THE ALLOWABLE MAXIMUM FREQUENCY FOR THE PROCEDURE IS 1 TIME PER CALENDAR MONTH
3292	MGAF - THE PRESENCE OF MODIFIER GA INDICATES THIS IS NOT ELIGIBLE FOR PAYMENT
3293	MGXF - THE PRESENCE OF MODIFIER GX INDICATES THIS IS NOT ELIGIBLE FOR PAYMENT
3294	MGYF - THE PRESENCE OF MODIFIER GY INDICATES THIS IS NOT ELIGIBLE FOR PAYMENT
3295	MGZF - THE PRESENCE OF MODIFIER GZ INDICATES THIS IS NOT ELIGIBLE FOR PAYMENT
3296	MHBF - A DIAGNOSIS CODE(S), WHICH MEETS MEDICAL NECESSITY FOR PROCEDURE CODE IS MISSING
3297	MI10F - PER CMS GUIDELINES, ICD-10 CODES CANNOT BE BILLED FOR DATES OF SERVICE PRIOR TO OCTOBER 1, 2015
3298	MI9F - ICD-9 CODE TYPES CANNOT BE BILLED FOR DATES OF SERVICE GREATER THAN SEPTEMBER 30, 2015
3299	MIC - PER MEDICARE GUIDELINES, PROCEDURE CODE IS A SERVICE COVERED INCIDENT TO A PHYSICIANS SERVICE AND MODIFIER 26 OR TC IS NOT APPROPRIATE
3300	MIM - MODIFIER IS NOT APPROPRIATE FOR PROCEDURE CODE
3301	ML1 - MODIFIER L1 IS INAPPROPRIATE TO BE REPORTED ON A PROFESSIONAL CLAIM
3302	MMFL - MMFL - PER CMS GUIDELINES, THE ASSOCIATED ADMINISTRATION OR DRUG CODE FOR VACCINE CODE IS MISSING OR INVALID
3303	MMFQ - A SEVERITY/COMPLEXITY MODIFIER, CH, CI, CJ, CK, CL, CM, CN IS REQUIRED TO BE APPENDED TO MEDICARE NONPAYABLE FUNCTION-RELATED G-CODES
3304	MMSP - PER MEDICARE GUIDELINES THE DIAGNOSIS CODE(S) BILLED DOES NOT SUPPORT THE MEDICAL NECESSITY OF G0101
3305	MMUE - PER MEDICARES MEDICALLY UNLIKELY EDITS, THE UNITS OF SERVICE BILLED FOR PROCEDURE CODE EXCEED THE ALLOWED UNITS
3306	MNC - PER MEDICARE GUIDELINES, THE HCPCS CODE OR MODIFIER BILLED IS A NON-COVERED HCPCS CODE OR MODIFIER
3307	MNE - PER CMS GUIDELINES, THIS PROCEDURE IS CONSIDERED TO BE A NON-COVERED SERVICE BECAUSE IT IS NOT DEEMED A MEDICAL NECESSITY BY THE PAYER
3308	MNV - PROCEDURE CODE IS NOT VALID FOR MEDICARE PURPOSES
3309	MOD50A - MODIFIER 50 IS NOT RECOGNIZED IN AN AMBULATORY SURGICAL CENTER (ASC)
3310	MODEF - MODIFIER EE OR ED MUST BE SUBMITTED ON CODES J0882 OR Q4081 WHEN VALUE CODE 48 IS GREATER THAN 13.0 OR VALUE CODE 49 IS GREATER THAN 39.0
3311	MODGF - CODE 90999 IS MISSING APPROPRIATE URR MODIFIER (G1-G6)
3312	MODJF - MODIFIER JA OR JB MUST BE SUBMITTED WITH CODE Q4081 OR J0882
3313	MODNEF - HCPCS CODES J0881 AND J0885 MUST BE SUBMITTED WITH MODIFIER EA, EB OR EC
3314	MODTCA - MODIFIER TC IS REQUIRED
3315	MODV2F - MODIFIER V5, V6 OR V7 MUST BE SUBMITTED WITH REVENUE CODE 0821
3316	MPDP - THE PD MODIFIER MUST BE BILLED WITH THE 26 MODIFIER
3317	MPDT - THE PD MODIFIER MAY NOT BE BILLED WITH THE TC MODIFIER
3318	MPNF - A DIAGNOSIS CODE(S), WHICH MEETS MEDICAL NECESSITY FOR PROCEDURE CODE IS MISSING
3319	MSE - PER MEDICARE GUIDELINES THE PROCEDURE CODE BILLED IS AN ITEM OR SERVICE THAT IS EXCLUDED FROM THE NATIONAL PHYSICIAN FEE SCHEDULE BY REGULATION
3320	MSM - PER MEDICARE GUIDELINES THE PROCEDURE CODE BILLED IS AN ITEM OR SERVICE THAT MEDICARE CONSIDERS A MEASUREMENT CODE AND IS USED FOR REPORTING PURPOSES ONLY
3321	MSR - PER MEDICARE GUIDELINES THE PROCEDURE CODE BILLED IS AN ITEM OR SERVICE THAT HAS RESTRICTED COVERAGE
3322	MSX - PER MEDICARE GUIDELINES THE PROCEDURE CODE IS AN ITEM OR SERVICE THAT IS NOT IN THE STATUTORY DEFINITION OF PHYSICIAN SERVICES FOR FEE SCHEDULE PAYMENT. NO RVUS OR PAYMENTS ARE SHOWN, AND NO PAYMENT MAY BE MADE UNDER THE PHYSICIAN FEE SCHEDULE
3323	MTH - PER MEDICARE GUIDELINES PROCEDURE CODE REQUIRES MODIFIER GT OR GQ
3324	MTRF - PER MEDICARE GUIDELINES, A MULTIPLE PROCEDURE REDUCTION SHOULD BE APPLIED TO THIS CLAIM LINE
3325	MUEDF - PER MEDICARE DME MEDICALLY UNLIKELY EDITS, THE UNITS OF SERVICE BILLED FOR PROCEDURE CODE EXCEED THE ALLOWED UNITS
3326	MUEF - PER MEDICARES MEDICALLY UNLIKELY EDITS, THE UNITS OF SERVICE BILLED FOR PROCEDURE CODE EXCEED THE ALLOWED UNITS
3327	NEA - PER MEDICARE GUIDELINES, THESE ARE CONSIDERED TO BE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A MEDICAL NECESSITY BY THE PAYER
3328	NERF - HCPCS CODES J0881 AND J0885 MUST BE REPORTED WITH REVENUE CODE 0636
3329	NPT - THIS PATIENT RECEIVED CARE BY PROVIDER WITHIN THREE YEARS OF PROCEDURE CODE ON CURRENT LINE. AN ESTABLISHED PATIENT E/M CODE SHOULD BE USED
3330	NPTF - THIS PATIENT RECEIVED CARE BY THE SAME PROVIDER WITHIN THE LAST THREE YEARS. AN ESTABLISHED PATIENT E/M CODE SHOULD BE USED
3331	NPTH - A NEW PATIENT E/M WAS REPORTED WITHIN THE LAST THREE YEARS. AN ESTABLISHED PATIENT E/M CODE SHOULD HAVE BEEN USED
3332	OBA - ANTEPARTUM CARE CODE CANNOT BE SUBMITTED 280 DAYS PRIOR TO GLOBAL DELIVERY CODES 59400, 59510, 59610, 59618 BY THE SAME PROVIDER
3333	OBAH - ANTEPARTUM CARE CODE 59425 OR 59426 WAS FOUND IN HISTORY. ANTEPARTUM CARE CODES MAY NOT BE SUBMITTED 280 DAYS PRIOR TO GLOBAL DELIVERY CODE
3334	OCD51F - OCCURRENCE CODE 51 MUST BE SUBMITTED ON ALL ESRD CLAIMS UNLESS VALUE CODE D5 WITH AMOUNT 9.99 OR 8.88 IS PRESENT

3335	ONL - ONLINE CODE CANNOT BE REPORTED FOR SERVICES RELATED TO AN E/M PROVIDED IN THE PREVIOUS 7 DAYS
3336	ORSF - INAPPROPRIATE TYPE OF BILL OR REVENUE CODE FOR OUTPATIENT REHABILITATION SERVICE
3337	OTFRF - THIS PROCEDURE CODE REQUIRES FUNCTIONAL REPORTING HCPCS CODE(S)
3338	OTFRMF - THIS OUTPATIENT THERAPY FUNCTIONAL REPORTING HCPCS CODE REQUIRES A SEVERITY/COMPLEXITY MODIFIER
3339	OTSF - ONLY ONE THERAPY MODIFIER CAN BE REPORTED ON A LINE OF SERVICE
3340	OUEDF - CODES Q4081 AND J0882 MUST BE SUBMITTED WITH CODE G0257
3341	PDIF - PRINCIPAL DIAGNOSIS OF 585.6 IS REQUIRED ON ALL 072X ESRD CLAIMS
3342	PDSF - CODE 90935 MUST BE SUBMITTED ON TOBS 012X, 013X OR 085X
3343	PISA - MEDICARE DOES NOT PAY SEPARATELY FOR THIS SERVICE
3344	PMODEF - CODE J0890 MUST BE SUBMITTED WITH MODIFIER ED OR EE IF VALUE CODE 48 IS GREATER THAN 13.0 OR VALUE CODE 49 IS GREATER THAN 39.0
3345	PMODF - CODE J0890 MUST BE REPORTED WITH MODIFIER JA OR JB
3346	POSA - PROCEDURE CODE IS NOT TYPICALLY PERFORMED IN AN ASC SETTING
3347	POSMA - PLACE SERVICE CODE 24 IS REQUIRED WITH PROVIDER SPECIALTY CODE 49 AND TYPE OF SERVICE CODE F
3348	PPGD - IT IS NOT APPROPRIATE TO SUBMIT POSTPARTUM CODE 59430 WITHIN 49 DAYS OF AN OBSTETRICAL PACKAGE CODE FOUND ON CLAIM
3350	PSC1F - THE PATIENT STATUS CODE IS INVALID
3351	PSCF - THE PATIENT DISCHARGE STATUS CODE IS MISSING
3352	PSXA - THE GENDER FOR THIS PATIENT IS EITHER MISSING OR INVALID
3353	PVCDF - CODE J0890 MUST NOT REPORT DEFAULT VALUE 99.99 FOR VALUE CODE 48 OR VALUE CODE 49
3354	QSTF - PER MEDICARE, QUALIFIED STAY REQUIREMENTS HAVE NOT BEEN MET
3355	RAP1F - ALL RAP CLAIMS (TOBS 0322, 0328, 0332 OR 0338) MUST BE SUBMITTED WITH REVENUE CODE 0023
3356	RCSF - MUST USE REVENUE CODE THAT IS TO THE HIGHEST SPECIFICITY; 0880 IS NOT SPECIFIED
3357	RDXF - REQUIRED PRINCIPAL OR OTHER DIAGNOSIS MISSING
3358	RMEGF - REVENUE CODE 0860 OR 0861 IS SUBMITTED WITH INAPPROPRIATE TYPE OF BILL
3359	RPDSF - PATIENT DISCHARGE STATUS 30 MUST BE SUBMITTED ON ALL REQUEST FOR ANTICIPATED PAYMENT (RAP) CLAIMS
3360	SAG - PER MEDICAID GUIDELINES, THE PATIENTS AGE DOES NOT MEET POLICY REQUIREMENTS FOR THE PROCEDURE CODE AND/OR A DIAGNOSIS CODE
3361	SAM - PER MEDICAID GUIDELINES, THIS HCPCS CODE IS IDENTIFIED AS AN AMBULANCE CODE AND REQUIRES AN AMBULANCE MODIFIER APPENDED
3362	SANE - PER MEDICAID GUIDELINES, BASED ON ANESTHESIA CODE AND MODIFIER , A REDUCTION IN THE BASE UNITS OR ALLOWED AMOUNT SHOULD BE APPLIED TO THIS LINE
3363	SANM - PER MEDICAID GUIDELINES, ANESTHESIA CODE ON CLAIM LINE ID REQUIRES AN APPROPRIATE MODIFIER
3364	SAR - PER MEDICAID GUIDELINES, APPLY A 10% REDUCTION TO CLAIM LINES CONTAINING HCPCS CODE A0425 AND A0428 WHEN BILLED WITH AN ORIGIN/DESTINATION MODIFIER THAT CONTAINS G OR J IN ANY POSITION
3365	SAS - PER MEDICAID GUIDELINES, A STATUTORY PAYMENT RESTRICTION FOR ASSISTANTS AT SURGERY APPLIES TO PROCEDURE CODE
3366	SBC - PER MEDICAID GUIDELINES, PAYMENT FOR PROCEDURE CODE IS ALWAYS BUNDLED INTO PAYMENT FOR OTHER SERVICES
3367	SBI - PER MEDICAID GUIDELINES, PROCEDURE CODE IS AN ITEM OR SERVICE THAT HAS NO SEPARATE PAYMENT UNDER THE PHYSICIAN FEE SCHEDULE AND NOT PAYABLE
3368	SBNS - PER OREGON MEDICAID PRIORITIZED LIST, THE PROCEDURE AND DIAGNOSIS COMBINATION ARE BELOW THE LINE AND ARE CONSIDERED NON-COVERED SERVICES
3369	SBPHF - BILLS FOR A CONTINUOUS COURSE OF TREATMENT MUST BE SUBMITTED IN THE SAME SEQUENCE IN WHICH THE SERVICES ARE FURNISHED
3370	SBUN - PER MEDICAID GUIDELINES, PAYMENT FOR THIS PROCEDURE CODE IS ALWAYS BUNDLED INTO PAYMENT FOR OTHER SERVICES NOT SPECIFIED; NO SEPARATE PAYMENT IS MADE
3371	SCC - PER MEDICAID GUIDELINES, AN ADDITIONAL PROCEDURE CODE IS NEEDED TO MEET POLICY REQUIREMENTS
3372	SCFR - PER MEDICAID GUIDELINES, A COMPLETED CONSENT FORM IS REQUIRED. SEE MEDICAID POLICY FOR SPECIFIC DETAILS
3373	SCO - PER MEDICAID GUIDELINES, BILLING FOR CO-SURGEONS IS NOT PERMITTED FOR PROCEDURE CODE
3374	SD1 - PER MEDICAID GUIDELINES, PROCEDURE CODE REQUIRES REVIEW OF DOCUMENTATION TO ESTABLISH THE MEDICAL NECESSITY OF A SURGICAL ASSISTANT
3375	SD2 - PER MEDICAID GUIDELINES, PROCEDURE CODE REQUIRES A REVIEW OF DOCUMENTATION TO ESTABLISH THE MEDICAL NECESSITY OF TWO SURGEONS
3376	SD3 - PER MEDICAID GUIDELINES, PROCEDURE CODE REQUIRES DOCUMENTATION TO ESTABLISH THE MEDICAL NECESSITY OF A SURGICAL TEAM
3377	SDOC - PER MEDICAID GUIDELINES, APPROPRIATE DOCUMENTATION MUST BE SUBMITTED OR REVIEWED TO ENSURE PROPER BILLING
3378	SDOCH - PER MEDICAID GUIDELINES, APPROPRIATE DOCUMENTATION MUST BE SUBMITTED TO ENSURE PROPER BILLING. REVIEW MEDICAID POLICY
3379	SDSP - PER MEDICAID GUIDELINES, A PRIMARY DIAGNOSIS CODE, WHICH MEETS MEDICAL NECESSITY FOR THE PROCEDURE CODE IS MISSING
3380	SDT - PER MEDICAID GUIDELINES, PROCEDURE CODE DESCRIBES A DIAGNOSTIC PROCEDURE THAT REQUIRES A PROFESSIONAL COMPONENT MODIFIER IN PLACE OF SERVICE
3381	SEH - PER MEDICAID GUIDELINES, CLAIM LINE IN HISTORY CONTAINS E/M CODE BILLED ON THE SAME DAY OF A MINOR PROCEDURE OR THE SAME DAY OR DAY BEFORE A MAJOR PROCEDURE. AN APPROPRIATE MODIFIER IS REQUIRED
3382	SEM - BUNDLED-PER MEDICAID GUIDELINES, E/M CODE BILLED ON THE SAME DAY OF A MINOR PROCEDURE OR THE SAME DAY OR DAY BEFORE A MAJOR PROCEDURE
3383	SEV - BUNDLED-PER MEDICAID GUIDELINES, PROCEDURE CODE WAS PERFORMED ON THE SAME DAY OF PROCEDURE CODE
3384	SFL - PER MEDICAID GUIDELINES, A DIAGNOSIS CODE(S), WHICH MEETS MEDICAL NECESSITY FOR PROCEDURE CODE IS MISSING
3385	SFP - PER MEDICAID GUIDELINES, E/M CODE IS WITHIN THE GLOBAL PERIOD OF PROCEDURE CODE FOUND IN HISTORY SUBMITTED BY THE SAME PROVIDER
3386	SFP24 - BUNDLED AS INCLUDED IN THE GLOBAL PERIOD
3387	SFP24H - PER MEDICAID GUIDELINES, PROCEDURE CODE EXISTS IN HISTORY WITH THE SAME DIAGNOSIS BY THE SAME PROVIDER AS THE SUBMITTED PROCEDURE CODE DURING THE GLOBAL PERIOD FOR THE SAME PATIENT
3388	SFPH - PER MEDICAID GUIDELINES, E/M CODE EXISTS IN HISTORY WITH THE SAME DIAGNOSIS CODE OF BY THE SAME PROVIDER AS PROCEDURE CODE DURING THE GLOBAL PERIOD FOR THE SAME PATIENT

3389	SFR - PER MEDICAID GUIDELINES, THE FREQUENCY DOES NOT MEET POLICY REQUIREMENTS FOR THE PROCEDURE CODE
3390	SFR - PER MEDICAID GUIDELINES, THE FREQUENCY DOES NOT MEET POLICY REQUIREMENTS FOR THE PROCEDURE CODE
3391	SGT - PER MEDICAID GUIDELINES, MODIFIER IS INAPPROPRIATELY APPENDED TO PROCEDURE CODE
3392	SHB - PER MEDICAID GUIDELINES, A DIAGNOSIS CODE(S), WHICH MEETS MEDICAL NECESSITY FOR PROCEDURE CODE IS MISSING
3393	SHCP - PER MEDICAID GUIDELINES, THE REQUIRED HCPCS, CPT, OR ICD PROCEDURE CODE IS MISSING OR INAPPROPRIATE
3394	SIC - PER MEDICAID GUIDELINES, PROCEDURE CODE IS A SERVICE COVERED INCIDENT TO A PHYSICIANS SERVICE AND MODIFIER TC OR 26 IS NOT APPROPRIATE
3395	SIM - PER MEDICAID GUIDELINES, MODIFIER IS NOT APPROPRIATE FOR PROCEDURE CODE
3396	SIN - PER MEDICAID GUIDELINES, PROCEDURE CODE IS CONSIDERED A BUNDLED SERVICE WHEN OTHER PAYABLE SERVICES ARE BILLED ON THE SAME DAY BY THE SAME PROVIDER
3397	SINH - PER MEDICAID GUIDELINES, THE PROCEDURE CODE IN HISTORY IS CONSIDERED A BUNDLED SERVICE WITH PROCEDURE CODE WHEN OTHER PAYABLE SERVICES ARE BILLED ON THE SAME DAY BY THE SAME PROVIDER
3398	SLP - PER MEDICAID GUIDELINES, PROCEDURE CODE IS INAPPROPRIATE WITH MODIFIER TC. PERFORMANCE OF THE TEST IS PAID UNDER THE LAB FEE SCHEDULE
3399	SM54 - PER MEDICAID GUIDELINES, THE PRESENCE OF MODIFIER 54 INDICATES THAT ONLY THE INTRAOPERATIVE PORTION OF THE GLOBAL FEE SHOULD BE REIMBURSED
3400	SM55 - PER MEDICAID GUIDELINES, THE PRESENCE OF MODIFIER 55 INDICATES THAT ONLY THE POSTOPERATIVE PORTION OF THE GLOBAL FEE SHOULD BE REIMBURSED
3401	SM56 - PER MEDICAID GUIDELINES, THE PRESENCE OF MODIFIER 56 INDICATES THAT ONLY THE PREOPERATIVE PORTION OF THE GLOBAL FEE SHOULD BE REIMBURSED
3402	SM62 - MODIFIER 62 IS PRESENT ON PROCEDURE CODE . THE SAME PROCEDURE CODE WITHOUT MODIFIER 62 APPENDED WAS REPORTED BY A DIFFERENT PROVIDER
3403	SM62H - MODIFIER 62 IS NOT PRESENT ON PROCEDURE CODE . THE SAME PROCEDURE CODE IN HISTORY WITH MODIFIER 62 APPENDED WAS REPORTED BY A DIFFERENT PROVIDER
3404	SM66 - MODIFIER 66 IS PRESENT ON PROCEDURE CODE . THE SAME PROCEDURE CODE WITHOUT MODIFIER 66 APPENDED WAS REPORTED BY A DIFFERENT PROVIDER
3405	SM66H - MODIFIER 66 IS NOT PRESENT ON PROCEDURE CODE . THE SAME PROCEDURE CODE IN HISTORY WITH MODIFIER 66 APPENDED WAS REPORTED BY A DIFFERENT PROVIDER
3406	SM78 - MANUAL PRICING- PER MEDICAID GUIDELINES, MODIFIER 78 INDICATES THAT ONLY THE INTRAOPERATIVE PORTION OF THE GLOBAL FEE MAY BE REIMBURSED
3407	SMEY - PER MEDICAID GUIDELINES, ALL CLAIM LINES ON THE SAME CLAIM MUST CONTAIN THE MODIFIER EY
3408	SMGK - PER MEDICAID GUIDELINES, MODIFIER GK CANNOT BE SUBMITTED ALONE, ANOTHER LINE WITH GA OR GZ MUST BE PRESENT ON THE SAME CLAIM
3409	SMGY - PER MEDICAID GUIDELINES, THE PRESENCE OF MODIFIER GY INDICATES THIS IS NOT ELIGIBLE FOR PAYMENT
3410	SMGY - PER MEDICAID GUIDELINES, THE PRESENCE OF MODIFIER GY INDICATES THIS IS NOT ELIGIBLE FOR PAYMENT
3411	SMGZ - PER MEDICAID GUIDELINES, THE PRESENCE OF MODIFIER GZ INDICATES THIS SERVICE/ITEM IS NOT ELIGIBLE FOR PAYMENT
3412	SMN - PER MEDI-CAL GUIDELINES, THE REQUIRED DIAGNOSIS IS MISSING
3413	SMUE - PER MEDICAID MEDICALLY UNLIKELY EDITS, THE UNITS OF SERVICE BILLED FOR PROCEDURE CODE EXCEED THE ALLOWED NUMBER OF UNITS
3414	SNCL - PER OREGON MEDICAID GUIDELINES, PROCEDURE CODE IS NOT INCLUDED IN THE PRIORITIZED LIST
3415	SNDRF - THE REVENUE CODE CANNOT BE SUBMITTED WITH TOB 022X
3416	SNE - PER MEDICAID GUIDELINES, THIS PROCEDURE IS CONSIDERED TO BE A NON-COVERED SERVICE BECAUSE IT IS NOT DEEMED A MEDICAL NECESSITY BY THE PAYER
3417	SNP - MNP - INCIDENTAL/BUNDLED WHEN PROVIDED IN POS BILLED
3418	SNR - PER MEDICAID GUIDELINES, THESE SERVICES ARE NOT REIMBURSABLE AS A SEPARATE CHARGE
3419	SNRH - PER MEDICAID GUIDELINES, SERVICES IN HISTORY ARE NOT REIMBURSABLE AS A SEPARATE CHARGE
3420	SNS - PER MEDICAID GUIDELINES, THIS PROCEDURE IS CONSIDERED A NON-COVERED SERVICE
3421	SOA2F - POINT OF ORIGIN FOR ADMISSION IS MISSING OR INVALID
3422	SPA - PER MEDICAID GUIDELINES, THIS PROCEDURE CODE REQUIRES PRIOR AUTHORIZATION
3423	SPC - PER MEDICAID GUIDELINES, PROCEDURE CODE DESCRIBES THE PHYSICIAN WORK PORTION OF A DIAGNOSTIC TEST. MODIFIER 26 OR TC ON CURRENT LINE ID IS NOT APPROPRIATE
3424	SPEC - PER MEDICAID GUIDELINES, CLAIM IS MISSING OR HAS AN INVALID PROVIDER SPECIALTY ID
3425	SPI - PER MEDICAID GUIDELINES, PROCEDURE CODE DESCRIBES A PHYSICIAN INTERPRETATION FOR A SERVICE AND IS NOT APPROPRIATE IN PLACE OF SERVICE
3426	SPN - PER MEDICAID GUIDELINES, A DIAGNOSIS CODE, WHICH MEETS MEDICAL NECESSITY FOR PROCEDURE CODE IS MISSING
3427	SPOS - PER MEDICAID GUIDELINES, THE PLACE OF SERVICE CODE IS MISSING OR INVALID FOR PROCEDURE CODE
3428	SPS - PER MEDICAID GUIDELINES, PROCEDURE CODE DESCRIBES THE PHYSICIAN SERVICE. USE OF MODIFIER 26 OR TC IS NOT APPROPRIATE
3429	SPT - PER MEDICAID GUIDELINES, PROCEDURE CODE IS A PHYSICAL THERAPY SERVICE. NO PAYMENT IS MADE IF PROVIDED IN PLACE OF SERVICE
3430	SRC - PER MEDICAID GUIDELINES, THE REQUIRED REVENUE CODE IS MISSING OR INAPPROPRIATE
3431	SSREV - PER MEDICAID GUIDELINES, ADDITIONAL MANUAL REVIEW MAY BE REQUIRED. REVIEW MEDICAID POLICY
3432	SRM - PER MEDICAID GUIDELINES, THE REQUIRED MODIFIER IS MISSING OR THE MODIFIER IS INAPPROPRIATE FOR THE PROCEDURE CODE
3433	SSB - PER MEDICAID GUIDELINES, ADD-ON PROCEDURE CODE HAS BEEN SUBMITTED WITHOUT AN APPROPRIATE PRIMARY PROCEDURE
3434	SSP -BUNDLED- PER MEDICAID GUIDELINES, PROCEDURE CODE IS WITHIN THE GLOBAL PERIOD OF PROCEDURE CODE FOUND ON HISTORY AND PERFORMED BY THE SAME PROVIDER
3435	SSPH - PER MEDICAID GUIDELINES, A PROCEDURE CODE FOUND IN HISTORY IS WITHIN THE GLOBAL PERIOD OF PROCEDURE CODE BY THE SAME PROVIDER FOR THE SAME PATIENT
3436	SSRA - PROCEDURE CODE MUST BE SUBMITTED WITH PROCEDURE CODE (15271 - 15278) ON THE SAME DATE OF SERVICE
3437	SSRF - PROCEDURE CODE MUST BE SUBMITTED WITH PROCEDURE CODE (15271 - 15278) ON THE SAME DATE OF SERVICE
3438	SSX - PER MEDICAID GUIDELINES, THE PATIENTS GENDER DOES NOT MEET POLICY REQUIREMENTS FOR THE PROCEDURE CODE AND/OR A DIAGNOSIS CODE

3439	STC - PER MEDICAID GUIDELINES, PROCEDURE CODE DESCRIBES ONLY THE TECHNICAL PORTION OF A SERVICE OR DIAGNOSTIC TEST. MODIFIER 26 OR TC IS NOT APPROPRIATE
3440	STOB - PER MEDICAID GUIDELINES, THE TYPE OF BILL DOES NOT MEET POLICY REQUIREMENTS
3441	STS - PER MEDICAID GUIDELINES, TEAM SURGERY IS NOT PERMITTED FOR PROCEDURE CODE
3442	SUB - PER MEDICAID GUIDELINES, PROCEDURE CODE HAS AN UNBUNDLE RELATIONSHIP WITH HISTORY PROCEDURE CODE ON THE CURRENT CLAIM
3443	SUBD - A DEFINITIVE ADD-ON PROCEDURE CODE HAS BEEN SUBMITTED WITHOUT AN APPROPRIATE PRIMARY PROCEDURE CODE
3444	SUBH - PER MEDICAID GUIDELINES, THE HISTORY PROCEDURE CODE HAS AN UNBUNDLE RELATIONSHIP WITH THE PROCEDURE CODE ON THE CURRENT CLAIM
3445	SUBH - AN ADD-ON PROCEDURE CODE HAD BEEN PREVIOUSLY SUBMITTED ON HISTORY CLAIM WITHOUT AN APPROPRIATE PRIMARY PROCEDURE CODE, REPORTED ON LINE ID
3446	SUBI - AN INTERPRETED ADD-ON CODE HAS BEEN SUBMITTED WITHOUT AN APPROPRIATE PRIMARY PROCEDURE CODE
3447	TCM - PROCEDURE IS INCLUDED IN TRANSITIONAL CARE MANAGEMENT SERVICE, 99495-99496, WHEN REPORTED IN THE SAME 30 DAY PERIOD
3448	TCMH - A PROCEDURE CODE FOUND IN HISTORY AND IS INCLUDED IN TRANSITIONAL CARE MANAGEMENT SERVICE, 99495-99496, WHEN REPORTED IN THE SAME 30 DAY PERIOD
3449	TCRF - A THERAPY CODE HAS BEEN SUBMITTED WITH INAPPROPRIATE THERAPY REVENUE CODE
3450	TEL - TELEPHONE CODE CANNOT BE REPORTED FOR SERVICES RELATED TO AN E/M PROVIDED IN THE PREVIOUS 7 DAYS
3451	TELH - A TELEPHONE CODE WAS FOUND IN HISTORY. TELEPHONE CODES CANNOT BE REPORTED WHEN THERE IS A DECISION TO SEE PATIENT WITHIN 24 HOURS
3452	TELN - TELEPHONE OR ONLINE CODE IS INTENDED TO BE REPORTED ON AN ESTABLISHED PATIENT. THIS PATIENT HAS NOT RECEIVED SERVICES BY THIS PROVIDER WITHIN THE PAST THREE YEARS
3453	TOBF - THE TYPE OF BILL CODE IS INVALID OR MISSING
3454	TPLF - A DIAGNOSIS CODE THAT IS A POSSIBLE THIRD PARTY LIABILITY SITUATION HAS BEEN SUBMITTED
3455	TPRA - THE SURGICAL PROCEDURE CODE CONTAINS A TERMINATED MODIFIER AND SHOULD BE REVIEWED FOR A 50% REDUCTION
3456	TRCF - A THERAPY SERVICE REVENUE CODE REQUIRES A THERAPY SERVICE MODIFIER
3457	TSMF - THERAPY SERVICE MODIFIER REQUIRES THERAPY SERVICE REVENUE CODE
3458	UNID - REPORT ONLY REMOTE SERVICES WHEN AN IN PERSON INTERROGATION DEVICE EVALUATION IS PERFORMED DURING THE SAME TIME PERIOD AS THE REMOTE INTERROGATION DEVICE EVALUATION
3459	UNIDH - AN IN PERSON INTERROGATION DEVICE EVALUATION CODE (93288-93291) WAS REPORTED WITH A REMOTE INTERROGATION DEVICE EVALUATION (93294-93299) OF THE SAME DEVICE DURING THE SAME PERIOD. ONLY THE REMOTE SERVICE MAY BE REPORTED
3460	UNLF - AN UNLISTED PROCEDURE CODE IS BILLED; A CORRESPONDING DESCRIPTION OF THAT PROCEDURE IS REQUIRED
3461	VCD5F - VALUE CODE D5 IS REQUIRED ON TOB 072X
3462	VCDF - VALUE CODE DEFAULT OF 99.99 CANNOT BE REPORTED ON CODE J0882 OR Q4081
3463	VCHF - AN APPROPRIATE VALUE CODE IS REQUIRED FOR HCPCS CODES Q4081 OR J0882
3464	VEN - PROCEDURE CODE HAS BEEN REPORTED ON THE SAME DATE OF SERVICE WITHOUT A CORRESPONDING VENIPUNCTURE CODE
3465	VRCF - VACCINE HCPCS CODES REQUIRE AN APPROPRIATE REVENUE CODE
3467	CALCULATED AMOUNT IS ZERO DUE TO COB CALCULATION
3468	092DDP - A DEVICE-DEPENDENT PROCEDURE CODE REQUIRES A DEVICE HCPCS CODE BE SUBMITTED ON THE SAME CLAIM, SAME DAY.
3469	HIPDXF - INVALID PRINCIPAL DIAGNOSIS CODE FOR HOSPICE BILL TYPE 081X AND 082X.
3470	IAGF - THE DIAGNOSIS CODE IS NOT TYPICAL FOR THE PATIENTS AGE.
3471	IWPSF - PASS-THROUGH CATEGORY HCPCS CODE C2624 MUST BE SUBMITTED WITH THE PROCEDURE CODE FOR RIGHT HEART CATHETERIZATION WITH IMPLANTATION OF WIRELESS PRESSURE SENSOR IN THE PULMONARY ARTERY ON THE SAME DATE OF SERVICE.
3472	MI10 - PER CMS GUIDELINES ICD9 CODES AND ICD10 CODES CANNOT BE BILLED ON THE SAME CLAIM.
3473	MI9 - PER CMS GUIDELINES ICD-9 CODES CANNOT BE BILLED WITH DATES OF SERVICE GREATER THAN SEPTEMBER, 30, 2015.
3474	POAEOF - THE OTHER DIAGNOSIS CODE IS EXEMPT FROM POA REPORTING.
3475	POAEPF - THE PRINCIPAL DIAGNOSIS CODE IS EXEMPT FROM POA REPORTING.
3476	POANOF - THE OTHER DIAGNOSIS CODE REQUIRES A PRESENT ON ADMISSION (POA) INDICATOR.
3477	POANPF - THE PRINCIPAL DIAGNOSIS CODE REQUIRES A PRESENT ON ADMISSION (POA) INDICATOR.
3478	SDSS - PER MEDICAID GUIDELINES, A SECONDARY DIAGNOSIS CODE, WHICH MEETS MEDICAL NECESSITY FOR THE PROCEDURE CODE IS MISSING OR INVALID.
3479	SNBT - PER MEDICAID GUIDELINES, PROCEDURE CODE CANNOT BE BILLED WITH ANOTHER PROCEDURE CODE ON THE CLAIM.
3480	SNBTH - PER MEDICAID GUIDELINES, PROCEDURE CODES FOUND IN HISTORY AND THIS PROCEDURE CODE CANNOT BE BILLED TOGETHER.
3481	SNDC - PER MEDICAID GUIDELINES, THIS PROCEDURE CODE REQUIRES AN APPROPRIATE NDC CODE.
3482	030DDC - THE OTHER DIAGNOSIS CODE IS A DUPLICATE OF ANOTHER OTHER DIAGNOSIS CODE ON THE CLAIM.
3483	INVALID AGE IN DAYS ON ADMISSION - TRICARE
3484	CANNOT PRICE THE CLAIM DUE TO LACK OF AUTHORIZATION
3485	UNABLE TO IDENTIFY PAYEE BY TAXONOMY CODE
3486	PRINCIPAL DIAGNOSIS SUGGESTS SURGERY
3487	ALL O.R. PROCEDURES CODED ARE NON-SPECIFIC
3488	TWO OR MORE DIFFERENT JOINT PROCEDURES ARE PRESENT
3489	CODE IS EXCLUDED FROM HAC-ADJUSTED GROUPING
3490	COULD NOT CREATE SOCKET
3491	COULD NOT CONNECT TO SERVER
3492	FAILURE IN SENDING CONNECTION STRING
3493	FAILURE TO RECEIVE CONNECTION RESPONSE
3494	CONNECTION CLOSED BETWEEN CONNECT AND SENDING OF CONNECTION STRING
3495	REQUEST XML NOT SENT SUCCESSFULLY
3496	RESPONSE NOT RECEIVED SUCCESSFULLY
3497	CENERAL CLIENT ERROR (200)
3498	UNSUPPORTED PROTOCOL VERSION (201)
3499	NOT AUTHORIZED. THE AUTHENTICATED CLIENT IS NOT ALLOWED TO MAKE REQUEST (202)
3500	UNRECOGNIZED REQUEST. THE HOST SYSTEM DID NOT RECOGNIZE THE METHOD SENT TO IT (203)
3501	UNRECOGNIZED REQUEST. THE HOST SYSTEM DID NOT RECOGNIZE THE CONTENT-TYPE HEADER VALUE (204)

3502	INVALID HEADER. A HEADER IN THE HEADERS SECTION WAS NOT FORMED CORRECTLY OR CONTAINED INVALID DATA (205)
3503	MALFORMED CONTENT (206)
3504	MISSING REQUIRED DATA. THE CONTENT WAS WELL-FORMED BUT DID NOT HAVE ALL REQUIRED DATA (207)
3505	INVALID FIELD VALUE. A FIELD IN THE CONTENT SECTION FAILED A VALIDATION CHECK (208)
3506	GENERAL SERVER ERROR (300)
3507	SYSTEM UNAVAILABLE. SOME COMPONENT OR COMPONENTS OF THE SYSTEM WERE NOT FUNCTIONING (301)
3508	DATABASE ERROR (302)
3509	RULES EXECUTION ERROR (303)
3510	REQUEST TIMED OUT. THE REQUEST WAS SENT TO THE INTERNAL SYSTEM BUT NO RESPONSE RECEIVED (304)
3511	SYSTEM FAILURE. AN OS RESOURCE WAS UNAVAILABLE. AN EXAMPLE WOULD BE AN OUTOFMEMORY EXCEPTION (305)
3512	SYSTEM CONFIGURATION ERROR. THE HOST SYSTEM DOES NOT HAVE ALL RESOURCES NECESSARY TO PROCESS REQUEST (306)
3513	CES FAILURE UNDOCUMENTED RETURN CODE
3514	SERVICE INCLUDED IN PER-ADMISSION RATE
3515	SERVICE COVERED WHEN REFERRED BY A PAR PCP
3516	MULTIPLE PAYEES MATCH TAXONOMY CODE
3517	INVALID ADMISSION / DISCHARGE OR OTHER DATES (EASYGROUP)
3518	CLOSED OR INACTIVE RATE RECORD (EASYGROUP)
3519	MEMBER HAS NOT AUTHORIZED USING LIFETIME RESERVE DAYS
3520	MISSING/INVALID ADMISSION DATE
3521	MISSING/INVALID DISCHARGE DATE
3522	CLAIM HAS MORE THAN 100 LINES, COULD NOT BE SENT TO WIZARD
3523	WIZARD/CLAIMCHECK RESULTED IN CLAIM WITH MORE THAN 100 LINES
3524	CLAIM HAS LINES ADDED BY WIZARD/CLAIMCHECK
3525	ASSESSMENT DATE IS MISSING
3526	NO ABEND OCCURRED BUT AN UNEXPECTED ACTION OCCURRED. REVIEW THE CLAIM-ABEND-MESSAGE FOR DETAILS.
3527	THE MCKESSON INTEGRATION MODULE FAILED PRIOR TO LOAD INVOKING THE INTEGRATION ENGINE OR AFTER SUCCESSFULLY CALLING THE INTEGRATION ENGINE. REVIEW THE CLAIM-ABEND-MESSAGE FOR DETAILS.
3528	THE INTEGRATION ENGINE FAILED WHILE ATTEMPTING TO LOAD INTEGRATION INFORMATION FROM THE INTEGRATION WIZARD DATABASE. REVIEW THE CLAIM-ABEND-MESSAGE FOR DETAILS.
3529	THE INTEGRATION ENGINE FAILED WHILE ATTEMPTING TO PREPARE THE INPUT CLAIM FOR AUDITING. REVIEW THE CLAIM-ABEND-MESSAGE FOR DETAILS.
3530	THE CALL TO CLAIMCHECK FAILED. REFERENCE THE CLAIM-ABEND-MESSAGE FOR DETAILS.
3531	THE INTEGRATION ENGINE DETECTED AN INVALID PROGRAMMING LANGUAGE INDICATOR. THIS SHOULD NOT OCCUR BUT IF IT DOES IT INDICATES AN INSTALLATION FAILURE OR PROGRAMMING BUG.
3532	INVALID ACTION INDICATOR. THE ACTION-IND VALUE INPUT TO THE INTEGRATION ENGINE WAS INVALID. THIS INDICATES THAT A CODING ERROR EXISTS IN THE MCKESSON INTEGRATION MODULE.
3533	THE PAM MODULE FAILED WHILE ATTEMPTING TO PERFORM PAM PROCESSING. REVIEW THE ABEND-MESSAGE FOR DETAILS.
3534	E322 - CLAIM MUST HAVE AT LEAST ONE CURRENT PROCEDURE
3535	E400 - FILE MUECUST UNAVAILABLE
3536	E449 - CENTURY REQUIRED FOR DATE OF BIRTH
3537	E330 - UNITS DO NOT MATCH DIFFERENCE BETWEEN FROM DATE & TO DATE IN DAYS
3538	E357 - UNITS DO NOT MATCH NUMBER OF SITE SPECIFIC MODIFIERS
3539	WIZARD DEFINED - UNITS MUST BE EQUAL TO SITE SPECIFIC MODIFIERS
3540	E377 - HISTORY STATUS INDICATOR MUST HAVE A VALID VALUE
3541	MMPN - PER CMS GUIDELINES, THE ASSOCIATED ADMINISTRATION OR DRUG CODE FOR VACCINE CODE IS MISSING OR INVALID
3542	MMHB - PER CMS GUIDELINES, THE ASSOCIATED ADMINISTRATION OR DRUG CODE FOR VACCINE CODE IS MISSING OR INVALID
3543	ERROR ACCESSING RATE FILES (EASYGROUP)
3544	GRPCNTL CANNOT BE LOADED (EASYGROUP)
3545	PRCCNTL CANNOT BE LOADED (EASYGROUP)
3546	PROGRAM CANNOT BE LOADED (EASYGROUP)
3547	INITIALIZATION ERROR (EASYGROUP)
3548	PARAMETER ERROR (EASYGROUP)
3549	MEMORY ALLOCATION CONTROL PROGRAM CANNOT BE LOADED (EASYGROUP)
3550	INVALID REQUEST - INVALID OPCODE1 (EASYGROUP)
3551	E-CODE/EXTERNAL CAUSES OF MORBIDITY CODE IS INVALID AS PRINCIPAL DIAGNOSIS (EASYGROUP)
3552	MANIFESTATION CODE IS INVALID AS PRINCIPAL DIAGNOSIS (EASYGROUP)
3553	NON-SPECIFIC CODE IS INVALID AS PRINCIPAL DIAGNOSIS (EASYGROUP)
3554	QUESTIONABLE ADMISSION (EASYGROUP)
3555	UNACCEPTABLE PRINCIPAL DIAGNOSIS (EASYGROUP)
3556	UNACCEPTABLE PRINCIPAL DIAGNOSIS, REQUIRES SECONDARY DIAGNOSIS (EASYGROUP)
3557	INSURER MAY BE SECONDARY PAYER TO AUTO INS, WORKERS COMP, ETC. (EASYGROUP)
3558	ADMIT DIAGNOSIS CODE FOR NEWBORNS ONLY (EASYGROUP)
3559	ADMIT DIAGNOSIS CODE FOR PEDIATRIC PATIENTS ONLY (EASYGROUP)
3560	ADMIT DIAGNOSIS CODE FOR MATERNITY-AGED PATIENTS ONLY (EASYGROUP)
3561	ADMIT DIAGNOSIS CODE FOR ADULTS ONLY (EASYGROUP)
3562	INSURER MAY BE SECONDARY PAYER TO AUTO INS, WORKERS COMP, ETC. BASED ON DIAGNOSIS (EASYGROUP)
3563	PROCEDURE IS TYPICALLY PERFORMED IN AN OPERATING ROOM (EASYGROUP)
3564	LENGTH OF STAY AND PROCEDURE ARE INCONSISTENT (EASYGROUP)
3565	PROCEDURE IS NOT TYPICALLY PERFORMED IN AN OPERATING ROOM (EASYGROUP)
3566	REVIEW FOR POSSIBLE TIMELY FILING EXCEPTION
3567	LATE FILING PENALTY
3568	THE TIME LIMIT FOR FILING HAS EXPIRED
3569	TYPE OF BILL ENTRY IS REQUIRED
3570	SERVICE EXISTS IN MULT AUTH TO CLM CATEGORIES
3571	093CTP - CORNEAL TISSUE PROCESSING HCPCS CODE REQUIRES A CORNEAL TRANSPLANT PROCEDURE SUBMITTED ON THE SAME DATE OF SERVICE
3572	094BMM - BIOSIMILAR HCPCS CODE REQUIRES A MODIFIER THAT IDENTIFIES THE MANUFACTURER OF THE SPECIFIC PRODUCT

3573	098LRP - CLAIM CONTAINS A PASS-THROUGH DEVICE CODE, BUT LACKS THE REQUIRED ASSOCIATED PROCEDURE
3574	099LPP - CLAIM CONTAINS A PASS-THROUGH OR NON-PASS-THROUGH DRUG OR BIOLOGICAL HCPCS CODE, BUT LACKS THE ASSOCIATED PAYABLE PROCEDURE THAT MUST BE SUBMITTED ON THE SAME CLAIM
3575	AKIDXF - ACUTE KIDNEY INJURY (AKI) CLAIM IS MISSING ONE OF THE REQUIRED ICD-10-CM DIAGNOSIS CODES
3576	AKIF -ACUTE KIDNEY INJURY (AKI) CODE G0491 AND END STAGE RENAL DISEASE (ESRD) HEMODIALYSIS CODE 90999 ARE NOT ALLOWED ON THE SAME CLAIM
3577	AKIHF - ACUTE KIDNEY INJURY (AKI) CODE SHOULD NOT BE REPORTED ON THE SAME DAY AS HEMODIALYSIS CODE ON A HISTORY CLAIM
3578	AKIPXF - THE ACUTE KIDNEY INJURY (AKI) CLAIM IS MISSING THE REQUIRED PROCEDURE CODE
3579	AKIRCF - THE ACUTE KIDNEY INJURY (AKI) CLAIM IS MISSING THE REQUIRED REVENUE CODE
3580	ARGF - ARGATROBAN, HCPCS CODE J0883 CAN NOT BE SUBMITTED ON TOB 072X
3581	CCC - PROCEDURE CODE IS INCLUDED IN COMPLEX CHRONIC CARE COORDINATION SERVICE, 99487-99488, WHEN REPORTED IN THE SAME CALENDAR MONTH
3582	CCCH - PROCEDURE CODE FOUND IN HISTORY CLAIM IS INCLUDED IN COMPLEX CHRONIC CARE COORDINATION SERVICE, 99487-99488, WHEN REPORTED IN THE SAME CALENDAR MONTH
3583	CCM1 - PROCEDURE CODE IS INCLUDED IN CHRONIC CARE MANAGEMENT SERVICE PROCEDURE CODE REPORTED ON PRIOR CLAIM WHEN REPORTED IN THE SAME CALENDAR MONTH
3584	CCM1H - PROCEDURE CODE FOUND IN HISTORY CLAIM IS INCLUDED IN CHRONIC CARE MANAGEMENT SERVICE PROCEDURE CODE WHEN REPORTED IN THE SAME CALENDAR MONTH
3585	CCM2 - CHRONIC CARE MANAGEMENT SERVICE PROCEDURE CODE IS INCLUDED IN PROCEDURE CODE REPORTED ON PRIOR CLAIM WHEN REPORTED IN THE SAME CALENDAR MONTH
3586	CCM2H - CHRONIC CARE MANAGEMENT SERVICE PROCEDURE CODE IN HISTORY CLAIM IS INCLUDED IN PROCEDURE CODE WHEN REPORTED IN THE SAME CALENDAR MONTH
3587	CFA - PROCEDURE CODE 22554 IS REPORTED BY A DIFFERENT PROVIDER. DOCUMENTATION INDICATING THAT THE SERVICE WAS PROVIDED ON A SEPARATE LEVEL MAY BE NECESSARY
3588	CFD - PROCEDURE CODE 63075 IS REPORTED BY A DIFFERENT PROVIDER. DOCUMENTATION INDICATING THAT THE SERVICE WAS PROVIDED ON A SEPARATE LEVEL MAY BE NECESSARY
3589	DARB1F - PER MEDICARE GUIDELINES, THE MAXIMUM NUMBER OF ADMINISTRATIONS OF DARBEPOETIN ALFA, HCPCS CODE FOR A BILLING CYCLE IS 5 TIMES IN 30/31 DAYS
3590	DCMD - CODES WERE TRANSLATED WITH DIAGNOSIS CODE MAPPINGS
3591	DLPC - CLAIM LINE HAS A DUPLICATE PROCEDURE CODE ON PRIOR FACILITY CLAIM FOR THE SAME DATE OF SERVICE.
3592	ESRDF - PER MEDICARE GUIDELINES, THE STATEMENT DATE RANGE CANNOT BE GREATER THAN 1 MONTH
3593	HHSNVF - INVALID HCPCS CODE FOR HOME HEALTH (HH) SKILLED NURSING VISIT FOR THE SERVICE DATE ON THE CLAIM LINE
3594	IBDCF - VALUE CODE FD REQUIRES A CONDITION CODE REPORTED ON THE CLAIM
3595	IDCD - PER THE ICD-10-CM EXCLUDES NOTE GUIDELINE, DIAGNOSIS CODES IDENTIFY TWO CONDITIONS THAT CANNOT BE REPORTED TOGETHER
3596	IDCDF - PER THE ICD-10-CM EXCLUDES NOTE GUIDELINE, DIAGNOSIS CODES IDENTIFY TWO CONDITIONS THAT CANNOT BE REPORTED TOGETHER
3597	LNM - INAPPROPRIATE USE OF A REPEAT MODIFIER 91 WITH LABORATORY PROCEDURE CODE
3598	LOCQRF - HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS) CLAIMS REQUIRE SPECIFIC REVENUE CODES WITH LOCATION CODE Q5001, Q5002 AND Q5009
3599	LPR - REPEATED LAB PROCEDURE MAY REQUIRE A REPEAT MODIFIER. THE SAME LAB PROCEDURE CODE WAS PERFORMED BY THE SAME PROVIDER ON THE SAME DAY
3600	MAYF - MODIFIER AYIS NOT ALLOWED ON AN ACUTE KIDNEY INJURY (AKI) CLAIM
3601	MBIO - PROCEDURE CODE NEEDS TO BE REPORTED WITH A MODIFIER THAT IDENTIFIES THE MANUFACTURER OF THE BIOSIMILAR BIOLOGICAL PRODUCT
3602	MEDICARE FREQUENCY LIMIT EXCEEDED
3603	MI10SCF - MEDICARE REQUIRES PROVIDERS TO SPLIT THE CLAIM SO ALL ICD-10 CODES REMAIN ON ONE CLAIM WITH DATES OF SERVICE (DOS) BEGINNING 10/1/2015 AND LATER. FOR DATES OF SERVICE ON OR AFTER OCTOBER 1, 2015, SUBMIT WITH THE APPROPRIATE ICD-10 CODES
3604	MI9SCF - MEDICARE REQUIRES PROVIDERS TO SPLIT THE CLAIM SO ALL ICD-9 CODES REMAIN ON ONE CLAIM WITH DATES OF SERVICE (DOS) THROUGH 9/30/2015. FOR DATES OF SERVICE PRIOR TO OCTOBER 1, 2015, SUBMIT CLAIMS WITH THE APPROPRIATE ICD-9 CODES
3605	MIAG - DIAGNOSIS CODE(S) IS NOT TYPICAL FOR AGE OF THE PATIENT
3606	MM62 - MODIFIER 62 IS NOT PRESENT ON PROCEDURE CODE. THE SAME PROCEDURE CODE WITH MODIFIER 62 APPENDED WAS REPORTED BY A DIFFERENT PROVIDER
3607	MM62H - MODIFIER 62 IS PRESENT ON PROCEDURE CODE. THE SAME PROCEDURE CODE WITHOUT MODIFIER 62 APPENDED WAS REPORTED BY A DIFFERENT PROVIDER
3608	MM66 - MODIFIER 66 IS NOT PRESENT ON PROCEDURE CODE. THE SAME PROCEDURE CODE WITH MODIFIER 66 APPENDED WAS REPORTED BY A DIFFERENT PROVIDER
3609	MM66H - MODIFIER 66 IS PRESENT ON PROCEDURE CODE. THE SAME PROCEDURE CODE IN HISTORY WITHOUT MODIFIER 66 APPENDED WAS REPORTED BY A DIFFERENT PROVIDER
3610	MMAT - PER MEDICARE GUIDELINES, MODIFIER AT IS REQUIRED WHEN BILLING PROCEDURE CODE FOR ACTIVE TREATMENT. MEDICARE DOES NOT PAY FOR MAINTENANCE THERAPY
3611	ONLH - ONLINE PROCEDURE CODE FOUND IN HISTORY CLAIM, CANNOT BE REPORTED FOR SERVICES RELATED TO AN E/M CODE PROVIDED IN THE PREVIOUS 7 DAYS
3612	PDO - ICD-10-CM CODE MAY ONLY BE USED AS FIRST-LISTED OR PRIMARY DIAGNOSIS POSITION
3613	PDSCF - PER MEDICARE GUIDELINES 45 UNITS IS ELIGIBLE FOR A 25% REDUCTION OF THE TECHNICAL COMPONENT
3614	POAEF - DIAGNOSIS CODE IS EXEMPT FROM POA REPORTING
3615	POANF - DIAGNOSIS CODE REQUIRES A PRESENT ON ADMISSION (POA) INDICATOR
3616	PRS - PROVIDER SPECIALTY IS INVALID
3617	RCNAF - CLAIM LINE REVENUE CODE NOT ALLOWED FOR RHC CLAIMS
3618	RCRHF - CLAIM LINE REVENUE CODE REQUIRES SUBMISSION OF A HCPCS CODE FOR RHC CLAIMS
3619	SBL - PER MEDICAID GUIDELINES, PROCEDURE CODE MUST BE SUBMITTED ON THE SAME CLAIM LINE WHEN BILLED WITH MODIFIERS RT AND LT ON THE SAME DATE OF SERVICE
3620	SBM - PER MEDICAID GUIDELINES, PROCEDURE CODE HAS NOT MET THE ASSOCIATED MODIFIER-CODE RELATIONSHIP CRITERIA
3621	SBT - PER MEDICAID GUIDELINES, ONLY ONE PROCEDURE CODE MAY BE REIMBURSED WHEN PROCEDURE CODE IS BILLED WITH HISTORY PROCEDURE CODE ON THE SAME DATE OF SERVICE
3622	SBTBF - TYPE OF BILL CODE SUBMITTED ON THE CLAIM IS INAPPROPRIATE FOR SCREENING DIGITAL BREAST TOMOSYNTHESIS
3623	SBTDF - SCREENING DIGITAL BREAST TOMOSYNTHESIS HCPCS CODE REQUIRES THE APPROPRIATE DIAGNOSIS CODE

3624	SBTH - PER MEDICAID GUIDELINES, ONLY ONE PROCEDURE CODE MAY BE REIMBURSED WHEN HISTORY PROCEDURE CODE FOUND ON HISTORY CLAIM IS BILLED WITH PROCEDURE CODE ON THE SAME DATE OF SERVICE
3625	SBTRF - SCREENING DIGITAL BREAST TOMOSYNTHESIS HCPCS CODE REQUIRES THE APPROPRIATE REVENUE CODE
3626	SCNA - PER MEDICAID GUIDELINES, THIS CODE HAS NOT YET BEEN ADOPTED AND IS NOT EFFECTIVE
3627	SDBTF - SCREENING DIGITAL BREAST TOMOSYNTHESIS HCPCS CODE REQUIRES THE APPROPRIATE PRIMARY MAMMOGRAM CODE
3628	SMPP - PER MEDICAID GUIDELINES, PROCEDURE CODE CANNOT BE BILLED WITHOUT FIRST BILLING THE PRIMARY PROCEDURE CODE
3629	SMVC - PER MEDICAID GUIDELINES, THE ASSOCIATED VACCINE CODE FOR ADMINISTRATION PROCEDURE CODE IS MISSING OR INVALID
3630	SNBC - PER MEDICAID GUIDELINES, PROCEDURE CODES ON CLAIM CANNOT BE BILLED TOGETHER ON SAME CLAIM FORM
3631	SNPT - PATIENT RECEIVED CARE BY PROVIDER ON PREVIOUS DATE OF SERVICE THAT IS WITHIN THREE YEARS. AN ESTABLISHED PATIENT E/M CODE SHOULD BE USED
3632	SNSI - PER MEDICAID GUIDELINES, THE PROCEDURE CODE IS CONSIDERED INVESTIGATIONAL AND IS A NON-COVERED SERVICE
3633	SNVT - PER MEDICAID GUIDELINES, PROCEDURE CODE IS NOT VALID FOR CLAIMS PROCESSING, THE USE OF ANOTHER CODE IS REQUIRED FOR REPORTING AND PAYMENT
3634	SPCI - PER MEDICAID GUIDELINES, PROCEDURE CODE BILLED WITH MODIFIER IS INAPPROPRIATE AND PROCEDURE CODE V5160 SHOULD BE BILLED AS THE CORRECT SERVICE
3635	SPMT - PER MEDICAID GUIDELINES, PROCEDURE CODE WITH MODIFIER CODE AND HISTORY PROCEDURE CODE WITH HISTORY MODIFIER CODE ON HISTORY CLAIM CANNOT BE BILLED TOGETHER
3636	SPNR - PER MEDICAID GUIDELINES, PROCEDURE CODE IS NOT REIMBURSABLE; USE APPROPRIATE PROCEDURE CODE E0445 RR
3637	SPNV - PER MEDICAID GUIDELINES, PROCEDURE CODE IS NOT APPROPRIATE WITH DIAGNOSIS CODE AND AGE OF PATIENT
3638	SRPD - PER MEDICAID GUIDELINES, REVENUE CODE WILL BE REIMBURSED ONE TIME PER DAY, REGARDLESS OF THE CHARGES OR NUMBER OF UNITS SUBMITTED
3639	SRR - PER MEDICAID GUIDELINES, THE REIMBURSEMENT AMOUNT FOR PROCEDURE CODE SHOULD BE REDUCED BASED ON REIMBURSEMENT OF PROCEDURE CODE FOUND ON HISTORY CLAIM
3640	SSNC - PER MEDICAID GUIDELINES, PROCEDURE CODE IS CONSIDERED A NON-COVERED SERVICE WHEN BILLED WITH HISTORY PROCEDURE CODE ON HISTORY CLAIM
3641	SSNCH - PER MEDICAID GUIDELINES, HISTORY PROCEDURE CODE ON HISTORY CLAIM IS CONSIDERED A NON-COVERED SERVICE WHEN BILLED WITH PROCEDURE CODE
3642	SSPC - PER MEDICAID GUIDELINES, PROCEDURE CODE ON CLAIM HAS BEEN BILLED WITH MULTIPLE UNITS FOR THE SAME DATE OF SERVICE AND ON THE SAME LINE. SEPARATE CLAIM LINES MUST BE USED
3643	SSPN - PER MEDICAID GUIDELINES, EACH DATE OF SERVICE MUST BE BILLED ON A SEPARATE CLAIM LINE FOR PROCEDURE CODE
3644	STF - PER MEDICAID GUIDELINES, THIS CLAIM WAS NOT RECEIVED WITHIN THE ESTABLISHED FILING TIMEFRAME
3645	SUM - PER MEDICAID GUIDELINES, PROCEDURE CODE HAS AN UNBUNDLE RELATIONSHIP WITH A PROCEDURE CODE ON A HISTORY CLAIM
3646	SUMH - PER MEDICAID GUIDELINES, PROCEDURE CODE ON HISTORY CLAIM HAS AN UNBUNDLE RELATIONSHIP WITH PROCEDURE CODE ON CURRENT CLAIM
3647	SUP - PER MEDICAID GUIDELINES, PROCEDURE CODE WHEN BILLED WITH ANOTHER PROCEDURE CODE ON CLAIM IS INAPPROPRIATE AND PROCEDURE CODE E0250 SHOULD BE BILLED AS THE CORRECT SERVICE
3648	SUPH - PER MEDICAID GUIDELINES, PROCEDURE CODE FOUND IN HISTORY WHEN BILLED WITH PROCEDURE CODE IS INAPPROPRIATE AND PROCEDURE CODE E0250 SHOULD BE BILLED AS THE CORRECT SERVICE
3649	UNS - THE ICD-10-CM CODE(S) REPORTED DEFINE AN UNSPECIFIED OR NOT OTHERWISE SPECIFIED (NOS) ICD-10-CM DIAGNOSIS CODE. REVIEW DOCUMENTATION TO VERIFY WHETHER OR NOT A MORE SPECIFIC ICD-10-CM DIAGNOSIS CODE IS APPROPRIATE
3650	UNSL - THE ICD-10-CM CODE(S) REPORTED DEFINE AN UNSPECIFIED ICD-10-CM DIAGNOSIS CODE WHICH HAS AN EQUIVALENT CODE FOR LATERALITY (RIGHT OR LEFT). REVIEW DOCUMENTATION TO VERIFY WHETHER OR NOT A MORE SPECIFIC ICD-10-CM DIAGNOSIS CODE IS APPROPRIATE
3651	CODE TABLE FILE I/O ERROR (EASYGROUP)
3652	CANNOT LOAD PROGRAM (EASYGROUP)
3653	INVALID BILLING OF DEVICE CREDIT (EASYGROUP)
3654	NON-PAYMENT CLAIM - SNF (EASYGROUP)
3655	PAYMENT BASED ON ASC RATE (EASYGROUP)
3656	PAYMENT CAPPED AT PERCENT OF CHARGES (EASYGROUP)
3657	PAYMENT BASED ON PERCENT OF CHARGES (EASYGROUP)
3658	PAYMENT BASED ON CHARGES (EASYGROUP)
3659	COMMERCIAL SIGNIFICANT COVERED SERVICE; WAGE-ADJUSTED (EASYGROUP)
3660	COMMERCIAL ANCILLARY COVERED SERVICE; NOT WAGE-ADJUSTED (EASYGROUP)
3661	COMMERCIAL NON-COVERED SERVICE (EASYGROUP)
3662	SERVICES PAID AT CONTRACTED RATE (EASYGROUP)
3663	DOES NOT CONTRIBUTE TO OUTLIER PAYMENT (EASYGROUP)
3664	CONTRIBUTES TO OUTLIER PAYMENT (EASYGROUP)
3665	INVALID ALC DAYS/INTERRUPTED DAYS (EASYGROUP)
3666	INVALID OCCURRENCE DATE (EASYGROUP)
3667	INVALID SERVICE DATE OR OUT OF RANGE (EASYGROUP)
3668	WRONG PROCEDURE PERFORMED (EASYGROUP)
3669	ERROR OPENING APCRULE FILE (EASYGROUP)
3670	ERROR OPENING ACECCI2 FILE (EASYGROUP)
3671	ERROR OPENING ACEOCE2 FILE (EASYGROUP)
3672	ERROR OPENING ACCMI FILE (EASYGROUP)
3673	ERROR OPENING AOCEMI FILE (EASYGROUP)
3674	ERROR OPENING ACEMUE FILE (EASYGROUP)
3675	ERROR OPENING ACCISD FILE (EASYGROUP)
3676	ERROR OPENING AOCESD FILE (EASYGROUP)
3677	MANIFESTATION CODE NOT ALLOWED AS PRINCIPAL DIAGNOSIS (EASYGROUP)
3678	CLAIM LACKS REQUIRED PRIMARY CODE (EASYGROUP)
3679	CLAIM LACKS REQUIRED DEVICE CODE OR REQUIRED PROCEDURE CODE (EASYGROUP)
3680	SKIN SUBSTITUTE APPLICATION PROCEDURE WITHOUT APPROPRIATE PRODUCT CODE (EASYGROUP)
3681	FQHC CLAIM LACKS REQUIRED QUALIFYING VISIT CODE (EASYGROUP)
3682	INCORRECT REVENUE CODE REPORTED FOR FQHC PAYMENT CODE (EASYGROUP)
3683	ITEM OR SERVICE NOT COVERED UNDER FQHC PPS OR RURAL HEALTH CLINIC (EASYGROUP)

3684	DEVICE-DEPENDENT PROCEDURE CODE BILLED WITHOUT DEVICE CODE (EASYGROUP)
3685	CORNEAL TISSUE PROCESSING REPORTED WITHOUT CORNEA TRANSPLANT PROCEDURE (EASYGROUP)
3686	BIOSIMILAR HCPCS REPORTED WITHOUT BIOSIMILAR MODIFIER (EASYGROUP)
3687	WEEKLY PARTIAL HOSPITALIZATION SERVICES REQUIRE A MINIMUM OF 20 HOURS OF SERVICE AS EVIDENCED IN PHP PLAN OF CARE (EASYGROUP)
3688	PARTIAL HOSPITALIZATION INTERIM CLAIM FROM AND THROUGH DATES MUST SPAN MORE THAN 4 DAYS (EASYGROUP)
3689	PARTIAL HOSPITALIZATION SERVICES ARE REQUIRED TO BE BILLED WEEKLY (EASYGROUP)
3690	CLAIM WITH PASS-THROUGH DEVICE LACKS REQUIRED PROCEDURE (EASYGROUP)
3691	CLAIM WITH PASS-THROUGH OR NON-PASS-THROUGH DRUG OR BIOLOGICAL LACKS OPPS PAYABLE PROCEDURE (EASYGROUP)
3692	CLAIM FOR HSCT ALLOGENEIC TRANSPLANTATION LACKS REQUIRED REVENUE CODE LINE FOR DONOR ACQUISITION SERVICES (EASYGROUP)
3693	ITEM OR SERVICE WITH MODIFIER PN NOT ALLOWED UNDER PFS (EASYGROUP)
3694	NON-ALLOWED ITEM OR SERVICE (EASYGROUP)
3695	ITEMS AND SERVICES FOR WHICH PRICING INFORMATION AND CLAIMS DATA ARE NOT AVAILABLE (EASYGROUP)
3696	HOSPITAL PART B SERVICES PAID THROUGH A COMPREHENSIVE APC (EASYGROUP)
3697	HOSPITAL PART B SERVICES THAT MAY BE PAID THROUGH A COMPREHENSIVE APC (EASYGROUP)
3698	CONDITIONALLY PACKAGED LABORATORY SERVICES (EASYGROUP)
3699	NOT BILATERAL (EASYGROUP)
3700	PACKAGED AS PART OF COMPREHENSIVE APC (EASYGROUP)
3701	CONDITIONALLY PACKAGED - PAYMENT STATUS Q1, Q2, Q3 OR Q4 (EASYGROUP)
3702	CANNOT LOAD OR OPEN PROGRAM (EASYGROUP)
3703	NON-PAYMENT CLAIM - REHAB (EASYGROUP)
3704	CLAIM BYPASSED CES PROCESSING DUE TO REQUIRED INFORMATION NOT AVAILABLE TO BE PASSED TO CES
3705	HISTORY CLAIM NOT INCLUDED IN CES PROCESSING DUE TO REQUIRED INFORMATION NOT AVAILABLE TO BE PASSED TO CES
3706	FX MODIFIER PERCENTAGE OF TECHNICAL COMPONENT PRICING HAS BEEN APPLIED
3707	CT MODIFIER PERCENTAGE OF TECHNICAL COMPONENT PRICING HAS BEEN APPLIED
3708	INVALID HIPPS CODE, PART A ONLY (EASYGROUP)
3709	OPTUM CES INTERFACE TIMEOUT, CES BYPASSED (OPTUM CES)
3710	OTHER PROCEDURE CODE #6 IS INVALID
3711	OTHER PROCEDURE CODE #7 IS INVALID
3712	OTHER PROCEDURE CODE #8 IS INVALID
3713	OTHER PROCEDURE CODE #9 IS INVALID
3714	OTHER PROCEDURE CODE #10 IS INVALID
3715	OTHER PROCEDURE CODE #11 IS INVALID
3716	OTHER PROCEDURE CODE #12 IS INVALID
3717	OTHER PROCEDURE CODE #13 IS INVALID
3718	OTHER PROCEDURE CODE #14 IS INVALID
3719	OTHER PROCEDURE CODE #15 IS INVALID
3720	OTHER PROCEDURE CODE #16 IS INVALID
3721	OTHER PROCEDURE CODE #17 IS INVALID
3722	OTHER PROCEDURE CODE #18 IS INVALID
3723	OTHER PROCEDURE CODE #19 IS INVALID
3724	OTHER PROCEDURE CODE #20 IS INVALID
3725	OTHER PROCEDURE CODE #21 IS INVALID
3726	OTHER PROCEDURE CODE #22 IS INVALID
3727	OTHER PROCEDURE CODE #23 IS INVALID
3728	OTHER PROCEDURE CODE #24 IS INVALID
3729	COMPLEMENTARY PROCESSING HAS BEEN BYPASSED
3730	COB INFORMATION CONTAINS NON COVERED (A8) AMOUNT(S)
3731	NOT COVERED (EASYGROUP)
3732	GN-DRUG/BIOLOGICAL FEE SCHEDULE ITEM (EASYGROUP)
3733	GX-OTHER FEE SCHEDULE ITEM (EASYGROUP)
3734	KN-DRUG/BIOLOGICAL FEE SCHEDULE ITEM (EASYGROUP)
3735	KX-OTHER FEE SCHEDULE ITEM (EASYGROUP)
3736	INVALID OR MISSING VALUE CODE / VALUE AMOUNT (EASYGROUP)
3737	INVALID OR MISSING MODIFIER (EASYGROUP)
3738	IMPROPER BILLING OF MODIFIER AY (EASYGROUP)
3739	INVALID UNITS FOR HIPPS CODE-PART A ONLY (EASYGROUP)
3740	SERVICE LINE UNITS EXCEED BENEFITS UNIT RANGE, PLEASE SPLIT SERVICE LINE BY UNITS
3741	EASYGROUP BYPASSED SINCE CLAIM HAS REPRICING INFORMATION
3742	CLAIM ERRORS WERE OVERRIDDEN BASED ON PLAN RULE
3743	EXTENDED HOSPITAL RATE CALCULATOR RECORD NOT FOUND (EASYGROUP)
3744	ERROR READING THE EXTENDED HOSPITAL RATE CALCULATOR RECORD (EASYGROUP)
3745	APC RATE FILE I/O ERROR (EASYGROUP)
3746	MODIFIER PAIRING NOT ALLOWED ON THE SAME LINE
3747	MODIFIER REPORTED PRIOR TO FDA APPROVAL DATE (EASYGROUP)
3748	NO ONSET OF DIALYSIS DATE ON FILE
3749	MCKESSON MIM INTERFACE TIMEOUT, MIM BYPASSED
3750	MPPR DIAGNOSTIC IMAGING REDUCTION APPLIED
3751	REDUCTION TO TECHNICAL COMPONENT DUE TO CLAIM
3752	REDUCTION TO PROFESSIONAL COMPONENT DUE TO CLAIM
3753	REDUCTION TO PRACTICE EXPENSE DUE TO CLAIM
3754	MPPR THERAPY SERVICE REDUCTION APPLIED
3755	MPPR CARDIOVASCULAR REDUCTION APPLIED
3756	MPPR OPHTHALMOLOGY REDUCTION APPLIED
3757	N781-ALERT:PATIENT IS A MEDICAID/QUALIFIED MEDICARE BENEFICIARY. REVIEW YOUR RECORDS FOR ANY WRONGFULLY COLLECTED DEDUCTIBLE. THIS AMOUNT MAY BE BILLED TO A SUBSEQUENT PAYER.
3758	N782-ALERT:PATIENT IS A MEDICAID/QUALIFIED MEDICARE BENEFICIARY. REVIEW YOUR RECORDS FOR ANY WRONGFULLY COLLECTED COINSURANCE. THIS AMOUNT MAY BE BILLED TO A SUBSEQUENT PAYER.
3759	N783-ALERT:PATIENT IS A MEDICAID/QUALIFIED MEDICARE BENEFICIARY. REVIEW YOUR RECORDS FOR ANY WRONGFULLY COLLECTED COPAYMENTS. THIS AMOUNT MAY BE BILLED TO A SUBSEQUENT PAYER.
3760	PRIOR PAYMENTS EXIST ON MIM CREATED LINE WHICH IS NO LONGER IS GENERATED
3761	SERVICE NOT ELIGIBLE FOR ALL-INCLUSIVE RATE
3762	CLAIM REPORTED WITH PASS-THROUGH DEVICE PRIOR TO FDA APPROVAL FOR THE PROCEDURE

3763	ADD-ON CODE REPORTED WITHOUT REQUIRED PRIMARY PROCEDURE CODE
3764	THERAPY CODE WITHOUT MPFS RATE
3765	NO AVAILABLE APC/FEE SCHEDULE RATE RECORD
3766	REDUCTION OF ALLOWED BASED ON TECHNICAL COMPONENT REDUCTION OF CLAIM
3767	REDUCTION OF ALLOWED BASED ON PROFESSIONAL COMPONENT REDUCTION OF CLAIM
3768	REDUCTION OF ALLOWED BASED ON PRACTICE EXPENSE REDUCTION OF CLAIM
3769	PAYMENT IS SUBJECT TO CARDIOVASCULAR CAP
3770	PAYMENT IS SUBJECT TO OPHTHALMOLOGY CAP
3771	094BMA - ASC BIOSIMILAR HCPCS REPORTED WITHOUT BIOSIMILAR MODIFIER
3772	100TLR - HSCT ALLOGENEIC TRANSPLANT LACKS REQUIRED REVENUE CODE LINE FOR DONOR ACQUISITION
3773	101PNM - ITEM OR SERVICE WITH MODIFIER PN NOT ALLOWED UNDER PFS
3774	102PON - MODIFIERS PO AND PN CANNOT BE BILLED ON THE SAME CLAIM LINE
3775	103MPA - MODIFIER REPORTED PRIOR TO FDA APPROVAL DATE
3776	ACPF - ADVANCE CARE PLANNING
3777	AKIAXF - ACUTE KIDNEY INJURY (AKI) CLAIMS CANNOT REPORT MODIFIER AX
3778	AKIDBF - ACUTE KIDNEY INJURY (AKI) CLAIMS CANNOT REPORT HCPCS CODES J0604 AND J0606
3779	AOPF - ADD-ON PROCEDURE WITHOUT PRIMARY PROCEDURE
3780	ASNC - AMBULANCE SNF TO SNF TRANSFER-CCT
3781	CCMF - CHRONIC CARE MANAGEMENT (CCM) FREQUENCY RULE FOR RHC AND FQHC CLAIMS
3782	CCNAF - CONDITION CODE 54 NOT ALLOWED ON TOB
3783	CCQF - TYPE OF BILLS WITH FREQUENCY CODE Q MUST HAVE APPROPRIATE CONDITION CODES
3784	CTPA - ASC CORNEAL TISSUE PROCESSING REPORTED WITHOUT CORNEA TRANSPLANT PROCEDURE
3785	CTPF - ASC CORNEAL TISSUE PROCESSING REPORTED WITHOUT CORNEA TRANSPLANT PROCEDURE
3786	DRJGF - 340B DRUG REDUCTION
3787	DSOF - DISCHARGE STATUS REQUIRES OCCURRENCE CODE 55
3788	EPOBF - EPOETIN BETA NON-ESRD USE, HCPCS Q9973, CAN NOT BE SUBMITTED ON TOB 072X
3789	GFPH - GLOBAL FOLLOW-UP IN HISTORY - SAME PROVIDER
3790	GSPH - SURGICAL GLOBAL FOLLOWUP IN HISTORY - SAME PROVIDER
3791	HCCF - CONDITION CODE 85 REPORTED ON TYPE OF BILL (TOB) OTHER THAN HOSPICE
3792	HDMEF - HCPCS CODE E1399 MUST BE BILLED WITH REVENUE CODE 0292 ON HOME HEALTH CLAIMS
3793	HHEF - NEGATIVE PRESSURE WOUND THERAPY (NPWT) BILLED ON HOME HEALTH (HH) CLAIM, BILL TYPE 034X WITHOUT HH EPISODE CLAIM, BILL TYPE 032X IN HISTORY
3794	HHRRF - HOME HEALTH REVENUE CODE AND TOB
3795	HHSNF - HOME HEALTH CLAIM WITHOUT SKILLED NURSING MUST HAVE CONDITION CODE 54
3796	HHTFF - HOME HEALTH RAP TIMELY FILING
3797	HOCF - HOSPICE NOTICE OF ELECTION OR REVOCATION CLAIMS WITH OCCURRENCE CODE 56 REQUIRE CONDITION CODE D0
3798	HODF - DISCHARGE STATUS CODE 20 CANNOT BE USED ON HOSPICE CLAIMS
3799	HOOF - OCCURRENCE CODE 42 CANNOT BE SUBMITTED WITH CONDITION CODE 52 OR DISCHARGE STATUS CODES 50 OR 51 ON HOSPICE CLAIMS
3800	HOSVF - HOSPICE VACCINE CLAIM WITH REVENUE CODE OTHER THAN 0771 OR 0636
3801	HPL2F - HOSPICE FIVE DAY PAYMENT LIMIT FOR RESPITE CARE
3802	INFF - ONLY ONE INITIAL INFUSION SERVICE ALLOWED PER ENCOUNTER
3803	IPPEF - INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE) FREQUENCY RULE
3804	IRFOCF - OCCURRENCE CODE 50 REQUIRED FOR INPATIENT REHABILITATION FACILITIES
3805	LNMF - INAPPROPRIATE USE OF REPEAT LAB MODIFIER
3806	MACP - MEDICARE FREQUENCY FOR ADVANCED CARE PLANNING AS PREVENTIVE
3807	MACW - MEDICARE WAIVE DEDUCTIBLE AND CO-PAY FOR PREVENTIVE ADVANCED CARE PLANNING
3808	MAXF - MODIFIER AX MUST BE BILLED WITH HCPCS CODE J0604 OR J0606
3809	MAXRF - HCPCS CODE J0604 OR J0606 WITH MODIFIER AX MUST BE BILLED WITH REVENUE CODE 0636
3810	MCGF - MODIFIER CG FOR TYPE OF BILL 072X
3811	MDP - BUNDLED AS INCLUDED IN THE GLOBAL PERIOD
3812	MDPH - MEDICARE POST-OP UNRELATED SERVICE BY PROVIDER HISTORY
3813	MHFF - MENTAL HEALTH RHC FREQUENCY RULE
3814	MHSF - MENTAL HEALTH SERVICES RHC MUST BE BILLED WITH REVENUE CODE 0900
3815	MM04 - MEDICARE MODIFIER QG RULE FOR STATIONARY OXYGEN DELIVERY
3816	MMCT - CMS CT MODIFIER REDUCTION RULE
3817	MMDM - MEDICARE MODIFIERS AU, AV AND AW REQUIRED ON SELECT DME
3818	MMQF - MEDICARE MODIFIER QF RULE WITH PORTABLE OXYGEN DELIVERY IN HISTORY
3819	MMQG - MEDICARE MODIFIER QG RULE WITH PORTABLE OXYGEN IN HISTORY
3820	MMUR - MEDICARE PORTABLE X-RAY MODIFIER REQUIRED FOR MULTIPLE PATIENTS SEEN
3821	MONP - MEDICARE ALWAYS THERAPY
3822	MPXR - MEDICARE PORTABLE XRAY REDUCTION RULE
3823	MRFX - REDUCTION FOR FX AND FY MODIFIERS
3824	MSFF - RURAL HEALTH CLINIC (RHC) MEDICAL SERVICES QUALIFYING VISITS FREQUENCY
3825	MSPF - MEDICARE SCREENING PELVIC
3826	MSPHF - MEDICAL SERVICES AND PREVENTIVE HEALTH RHC MUST BE BILLED WITH REVENUE CODE 052X
3827	MTHP - TELEHEALTH PLACE OF SERVICE
3828	NOEDF - DATE OF CERTIFICATION MUST MATCH THE FROM AND ADMIT DATE FOR HOSPICE NOTICE OF ELECTION CLAIMS
3829	NPWTF - NEGATIVE PRESSURE WOUND THERAPY (NPWT) NOT ALLOWED ON HOME HEALTH TYPE OF BILL 032X
3830	OBC - TOTAL GLOBAL OBSTETRICAL CARE
3831	OBS - ANTEPARTUM CARE/DELIVERY/POSTPARTUM BY SPECIALTY
3832	PISF - ASC PACKAGED ITEM/SERVICE RULE
3833	POABF - PRESENT ON ADMISSION INDICATOR NOT VALID FOR TYPE OF BILL
3834	POAF - INVALID PRESENT ON ADMISSION (POA) INDICATOR
3835	RAPF - HOME HEALTH RAP CLAIM HIPPS AND REVENUE CODES
3836	RDL - REPEAT RADIOLOGY REQUIRES REPEAT MODIFIER
3837	REF - REFERRING PHYSICIAN MISSING
3838	RFVRF - PATIENT REASON FOR VISIT REQUIRED
3839	RHHF - REVENUE CODE 0559 CAN ONLY BE REPORTED WITH NEGATIVE PRESSURE WOUND THERAPY (NPWT) CODES ON HOME HEALTH TYPE OF BILL 034X
3840	RPAA - ASC ARGUS RETINAL PROSTHESIS ADD-ON CODE
3841	RPAF - ASC ARGUS RETINAL PROSTHESIS ADD-ON CODE
3842	RPIA - ASC RETINAL PROSTHESIS IMPLANTATION PROCEDURE
3843	RPIF - ASC RETINAL PROSTHESIS IMPLANTATION PROCEDURE
3844	RRCF - REVENUE CODE 0023 ONLY ALLOWED ONCE ON REQUEST FOR ANTICIPATED PAYMENT CLAIMS
3845	SAP - MEDICAID ADD-ON PROCEDURE

3846	SCM51 - MODIFIER 51-REQUIRED (EXEMPT FROM CUTBACK)
3847	SCN51 - SURGICAL MODIFIER REQUIRED
3848	SCNS - NON BENEFIT
3849	SDEY - DENY MODIFIER EY
3850	SDP BUNDLED AS INCLUDED IN GLOBAL PERIOD. MODIFIER MIGHT BE APPROPRIATE
3851	SDPH - MEDICAID POSTOPERATIVE UNRELATED SERVICE BY PROVIDER - DIFFERENT DIAGNOSIS
3852	SHACNF - MEDICAID HEALTH CARE-ACQUIRED CONDITION NON-EXEMPT DIAGNOSIS CODE
3853	SIP - SEQUENTIAL INTRAVENOUS PUSH REPORTED BY A PHYSICIAN
3854	SNFCF - SKILLED NURSING FACILITY HIPPS CHARGE AMOUNT
3855	SNFDF - SKILLED NURSING FACILITY DATE SPAN
3856	SNFH1F - SKILLED NURSING FACILITY REVENUE AND HIPPS CODES
3857	SNFHF - SKILLED NURSING FACILITY REVENUE AND HIPPS CODES
3858	SNFTF - SKILLED NURSING FACILITY TYPE OF BILL
3859	SPSL - RADIOLOGIC EXAMINATION MUST BILL ON SINGLE CLAIM LINE
3860	SUDL - INVALID BILLING. BILL LT AND RT ON SEPARATE LINES PER MC POLICY
3861	THSF - TELEHEALTH SERVICES MUST BE BILLED WITH REVENUE CODE 0780
3862	TOAFF - TYPE OF ADMISSION FREQUENCY
3863	TOBQF - BILL TYPE WITH FREQUENCY CODE Q CANNOT BE SUBMITTED WITHIN NORMAL TIMELY FILING PARAMETERS
3864	VCCCF - VALUE CODE 42 AND CONDITION CODE 26 MUST BOTH BE PRESENT
3865	WTRCF - NEGATIVE PRESSURE WOUND THERAPY (NPWT) CPT CODE MISSING APPROPRIATE REVENUE CODE
3866	TECHNICAL COMPONENT PRICE COULD NOT BE CALCULATED
3867	DRG/PRC CODE IS NOT VALID
3868	GMIS PAY PERCENTAGE APPLIED
3869	CLAIM ATTACHMENT ADDED FROM EHS
3870	QUESTIONABLE OBSTETRIC ADMISSION FOR THIS PROCEDURE CODE
3871	CODE FIRST DIAGNOSIS PRESENT WITHOUT MENTAL HEALTH DIAGNOSIS AS THE FIRST SECONDARY DIAGNOSIS
3872	SERVICE PROVIDED PRIOR TO INITIAL MARKETING DATE
3873	INVALID REHABILITATION CLAIM
3874	REVERSAL CLAIM BECAUSE OF MISSING INTEREST ON ORIGINAL CLAIM
3875	NEW CLAIM BECAUSE OF MISSING INTEREST ON ORIGINAL CLAIM
3876	WRONG PROCEDURE PERFORMED
3877	NO AVAILABLE APG/FEE SCHEDULE RATE RECORD
3878	VISIT CONSISTS OF ALL NEVER PAY OR STANDALONE
3879	SERVICE IS NEVER PAY
3880	INVALID AMBULATORY SURGICAL CENTER CLAIM
3881	CARVE-OUT SERVICE
3882	MISSING OR INVALID FEE SCHEDULE TYPE
3883	INVALID MODIFIER PAIR
3884	LINE ITEM REJECTION FROM EDITOR
3885	NO PAYMENT PER NEW YORK MEDICAID ANCILLARY POLICY
3886	PAYMENT REDUCTION PER NEW YORK MEDICAID ANCILLARY POLICY
3887	NO FACILITY RATE AVAILABLE
3888	INVALID OBSERVATION BILLING
3889	TELEHEALTH FACILITY FEE INVALID
3890	NEVER EVENT
3891	INVALID BILLING OF OFF-SITE SERVICES
3892	DIAGNOSIS AND PROCEDURE CONFLICT
3893	MISSING OR INVALID MODIFIER FOR PRICING
3894	CONSOLIDATED SERVICE
3895	NON-COVERED REVENUE CODE
3896	NO AVAILABLE EXTENDED FEE SCHEDULE RATE
3897	NON-COVERED SERVICE
3898	SERVICE EXCEEDED MAXIMUM ALLOWABLE UNITS
3899	FULL PAYMENT - PRICING METHOD
3900	CONSOLIDATED - PRICING METHOD
3901	SUBJECT TO DISCOUNTING - PRICING METHOD
3902	PACKAGED - PRICING METHOD
3903	NO PAYMENT - PRICING METHOD
3904	BILATERAL - PRICING METHOD
3905	DISCOUNTED BILATERAL - PRICING METHOD
3906	PERCENT OF CHARGES - PRICING METHOD
3907	PAID VIA FEE SCHEDULE - PRICING METHOD
3908	CAPPED AT CHARGES - PRICING METHOD
3909	ERROR CALLING MAPPER CONTROL PROGRAM (MAPCNTL)
3910	ERROR CALLING EDITOR CONTROL PROGRAM (EDTCNTL)
3911	ERROR CALLING GROUPER CONTROL PROGRAM (GRPCNTL)
3912	ERROR CALLING PRICER CONTROL PROGRAM (PRCCNTL)
3913	ERROR CALLING RETRIEVE PAYER CONTROL PROGRAM (RTVPYR)
3914	ERROR CALLING MODEL CONTROL PROGRAM (MDLCNTL)
3915	NON-ZERO RETURN CODE FROM MAPPER
3916	NON-ZERO RETURN CODE FROM DSC EDITOR
3917	NON-ZERO RETURN CODE FROM EASYEDIT
3918	NON-ZERO RETURN CODE FROM ACE, OR ACCEPT IF LESS THAN ACE DISP
3919	NON-ZERO RETURN CODE FROM GROUPER
3920	NON-ZERO RETURN CODE FROM PRICER
3921	NON-ZERO RETURN CODE FROM LCD EDITOR
3922	NON-ZERO RETURN CODE FROM RETRIEVE PAYER CONTROL PROGRAM (RTVPYR)
3923	NON-ZERO RETURN CODE FROM MODEL CONTROL PROGRAM
3924	NON-ZERO RETURN CODE FROM THE TRICARE APC EDITOR
3925	NON-ZERO RETURN CODE FROM PHYSICIAN EDITOR
3926	MEMORY ERROR
3927	INVALID PATIENT TYPE
3928	CONFIGURATION RECORD ERROR
3929	INVALID DATES
3930	INVALID BILLING WHEN NO SKILLED SERVICE
3931	INVALID THERAPY CODE AND REVENUE CODE COMBINATION

3932	INVALID OR MISSING FIPS CODE
3933	INVALID MODIFIER FOR PRICING
3934	CONTRACTOR PRICED ITEM REQUIRES ADDITIONAL SETUP FOR REIMBURSEMENT
3935	INVALID REVENUE CODE FOR PRICING
3936	IMPROPER BILLING OF DRUGS
3937	INVALID BILL TYPE
3938	INVALID NUMBER OF HIPPS CODES
3939	INVALID HIPPS CODE
3940	INVALID OR NO TREATMENT AUTHORIZATION CODE PROVIDED
3941	AUTHORIZATION CHECKING BYPASSED
3942	NO RUG OR HIPPS ON THIS CLAIM
3943	NO RATE AVAILABLE FOR RUG, HCPCS OR HIPPS CODE
3944	INVALID OR MISSING SNF CLAIM DATA
3945	INVALID OCCURRENCE DATE SPAN
3946	DENIAL CLAIM
3947	INVALID HIPPS CODE (PART A ONLY)
3948	SERVICE COST IS DUPLICATIVE, INCLUDED IN COST OF ASSOCIATED BIOLOGICAL (EASYGROUP)
3949	THIS CLAIM HAS BEEN REPLACED WITH CLAIM ID
3950	098LRPA - THIS CLAIM CONTAINS A PASS-THROUGH DEVICE CODE, BUT LACKS THE REQUIRED ASSOCIATED PROCEDURE
3951	102IMP - THE MODIFIER PAIRING ON THE CLAIM LINE IS NOT ALLOWED
3952	109CFP - A MENTAL HEALTH DIAGNOSIS CODE IS REQUIRED IN THE FIRST SECONDARY DIAGNOSIS POSITION WHEN A CODE FIRST DIAGNOSIS IS SUBMITTED AS THE PRINCIPAL DIAGNOSIS ON A PARTIAL HOSPITALIZATION CLAIM
3953	110SPM - THE HCPCS CODE ON THIS LINE IS BILLED PRIOR TO THE INITIAL MARKETING DATE
3954	BHCM - PROCEDURE CODE 99484 MAY NOT BE REPORTED WITH OTHER PROCEDURE CODE BILLED IN THE SAME CALENDAR MONTH
3955	BHCMH - PROCEDURE CODE 99484 ON ANOTHER CLAIM MAY NOT BE REPORTED WITH THIS PROCEDURE CODE IN THE SAME CALENDAR MONTH
3956	CAGF - PROCEDURE CODE IS NOT TYPICAL FOR PATIENTS AGE
3957	DIPAF - MEDICARE DOES NOT PAY SEPARATELY FOR THIS SERVICE
3958	HHHCF - REVENUE CODE 0023 CANNOT BE BILLED WITH CHARGES GREATER THAN $1.00
3959	ICRF - PER MEDICARE GUIDELINES, PROCEDURE CODE BILLED WITH MODIFIER 53 IS PAID AT A SPECIFIC RATE ESTABLISHED IN THE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)
3960	IDUP - DIAGNOSIS CODE(S) MAY ONLY BE REPORTED ONCE PER CLAIM LINE
3961	MB50 - PER MEDICARE GUIDELINES, A BILATERAL PROCEDURE CODE SUBMITTED WITH MODIFIER 50 AND BILLED WITH MORE THAN 1 UNIT OF SERVICE IS INAPPROPRIATE
3962	MLIH - PER MEDICARE GUIDELINES, PROCEDURE CODE DESCRIBES A DIAGNOSTIC PROCEDURE THAT REQUIRES A PROFESSIONAL COMPONENT MODIFIER IN POS
3963	MLTH - PER MEDICARE GUIDELINES, PROCEDURE CODE DESCRIBES A LABORATORY PROCEDURE THAT IS NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT IN PLACE OF SERVICE
3964	MPA - PER MEDICARE GUIDELINES, DMEPOS CODE REQUIRES PRIOR AUTHORIZATION
3965	MSED - A MODERATE SEDATION SERVICE WAS REPORTED IN CONJUNCTION WITH A SCREENING COLONOSCOPY SERVICE WITHOUT MODIFIER 33, COINSURANCE AND DEDUCTIBLE ARE WAIVED WHEN MODIFIER 33 IS ENTERED ON THE MODERATE SEDATION CLAIM LINE
3966	MSPR - PER MEDICARE GUIDELINES, PROCEDURE CODE HAS BEEN BILLED WITH A RELATED PROCEDURE CODE ON HISTORY CLAIM
3967	MTCH - PER MEDICARE GUIDELINES, PROCEDURE CODE DESCRIBES A DIAGNOSTIC PROCEDURE THAT IS NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT IN PLACE OF SERVICE
3968	OSRF - A REDUCTION SHOULD BE APPLIED TO HCPCS CODE WHEN REPORTED WITH MODIFIER PO
3969	PCCM - PROCEDURE CODE 99493 MAY NOT BE REPORTED WITH PROCEDURE CODE 99492 ON ANOTHER CLAIM WHEN REPORTED IN THE SAME CALENDAR MONTH
3970	PCCMH - PROCEDURE CODE 99493 FOUND IN HISTORY MAY NOT BE REPORTED WITH PROCEDURE CODE 99492 WHEN REPORTED IN THE SAME CALENDAR MONTH
3971	PCME - PROCEDURE CODE 99492 MAY ONLY BE REPORTED ONCE IN AN EPISODE OF CARE. A PERIOD OF 6 CALENDAR MONTHS HAS NOT PASSED SINCE PROCEDURE CODE WAS REPORTED ON ANOTHER CLAIM
3972	PHID - PROFESSIONAL HOME INFUSION THERAPY SERVICES CODE HAS BEEN REPORTED WITHOUT AN ASSOCIATED DRUG CODE. PROFESSIONAL VISIT CLAIM SHOULD BE REVIEWED WITH A 30-DAY LOOK BACK PERIOD FOR A TOTAL OF 15 BUSINESS DAYS
3973	PHIT - PROFESSIONAL HOME INFUSION THERAPY SERVICES CODE IS REPORTED ON THE SAME DATE OF SERVICE AS ANOTHER PROFESSIONAL HOME INFUSION THERAPY SERVICE CODE
3974	PHIT2 - A PROFESSIONAL HOME INFUSION THERAPY SERVICES CODE ON HISTORY CLAIM WAS REPORTED. THE PROFESSIONAL HOME INFUSION THERAPY SERVICES CODE ON THE CURRENT CLAIM IS REPORTED ON THE SAME DATE OF SERVICE AND SHOULD NOT BE ALLOWED
3975	SB50 - PER MEDICAID GUIDELINES, A BILATERAL PROCEDURE CODE SUBMITTED WITH MODIFIER 50 AND BILLED WITH MORE THAN 1 UNIT OF SERVICE IS INAPPROPRIATE
3976	SLIH - PER MEDICAID GUIDELINES, PROCEDURE CODE DESCRIBES A DIAGNOSTIC PROCEDURE THAT REQUIRES A PROFESSIONAL COMPONENT MODIFIER IN POS
3977	SLTH - PER MEDICAID GUIDELINES, PROCEDURE CODE DESCRIBES A LABORATORY PROCEDURE THAT IS NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT IN PLACE OF SERVICE
3978	SMOD - USE OF MODIFIER(S) IS NOT TYPICAL FOR PROCEDURE CODE
3979	SNSBF - INPATIENT SNF OR SWING BED TYPE OF BILL CODE REQUIRES DISCHARGE DISPOSITION 30 WHEN OCCURRENCE CODE 22 IS PRESENT ON THE CLAIM AND THE OCCURRENCE CODE DATE IS EQUAL TO THE THROUGH DATE OF THE CLAIM
3980	SSPR - PER MEDICAID GUIDELINES, PROCEDURE CODE HAS BEEN BILLED WITH A RELATED PROCEDURE CODE ON ANOTHER CLAIM
3981	STCH - PER MEDICAID GUIDELINES, PROCEDURE CODE DESCRIBES A DIAGNOSTIC PROCEDURE THAT IS NOT ELIGIBLE FOR SEPARATE REIMBURSEMENT IN PLACE OF SERVICE
3982	SUSPENDED FOR MANUAL REVIEW DUE TO MPPR PROCESSING
3983	HHA NOT ELIGIBLE FOR RAP REIMBURSEMENT
3984	PRINCIPAL DIAGNOSIS CODE NOT ASSIGNED TO A CLINICAL GROUP
3986	NO ALTERNATE PDGM AVAILABLE, OCCURRENCE CODE 61 OR 62 BILLED INCORRECTLY
3987	CLAIM SPANS CALENDAR YEAR
3988	NON-ZERO RETURN CODE FROM DSC EDITOR
3989	NON-ZERO RETURN CODE FROM ACE EDITOR
3990	INVALID OR MISSING TAXONOMY
3991	CANNOT LOAD OR OPEN PROGRAM
3992	INVALID PATIENT TYPE
3993	ERROR OPENING CONFIGURATION FILE

3994	PRINCIPAL DIAGNOSIS CODE IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
3995	ADMIT DIAGNOSIS CODE IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
3996	OTHER DIAGNOSIS CODE #1 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
3997	OTHER DIAGNOSIS CODE #2 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
3998	OTHER DIAGNOSIS CODE #3 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
3999	OTHER DIAGNOSIS CODE #4 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4000	OTHER DIAGNOSIS CODE #5 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4001	OTHER DIAGNOSIS CODE #6 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4002	OTHER DIAGNOSIS CODE #7 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4003	OTHER DIAGNOSIS CODE #8 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4004	OTHER DIAGNOSIS CODE #9 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4005	OTHER DIAGNOSIS CODE #10 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4006	OTHER DIAGNOSIS CODE #11 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4007	OTHER DIAGNOSIS CODE #12 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4008	OTHER DIAGNOSIS CODE #13 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4009	OTHER DIAGNOSIS CODE #14 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4010	OTHER DIAGNOSIS CODE #15 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4011	OTHER DIAGNOSIS CODE #16 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4012	OTHER DIAGNOSIS CODE #17 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4013	OTHER DIAGNOSIS CODE #18 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4014	OTHER DIAGNOSIS CODE #19 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4015	OTHER DIAGNOSIS CODE #20 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4016	OTHER DIAGNOSIS CODE #21 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4017	OTHER DIAGNOSIS CODE #22 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4018	OTHER DIAGNOSIS CODE #23 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4019	OTHER DIAGNOSIS CODE #24 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4020	OTHER DIAGNOSIS CODE #25 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4021	PRINCIPAL PROCEDURE CODE IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4022	OTHER PROCEDURE CODE #1 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4023	OTHER PROCEDURE CODE #2 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4024	OTHER PROCEDURE CODE #3 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4025	OTHER PROCEDURE CODE #4 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4026	OTHER PROCEDURE CODE #5 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4027	OTHER PROCEDURE CODE #6 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4028	OTHER PROCEDURE CODE #7 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4029	OTHER PROCEDURE CODE #8 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4030	OTHER PROCEDURE CODE #9 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4031	OTHER PROCEDURE CODE #10 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4032	OTHER PROCEDURE CODE #11 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4033	OTHER PROCEDURE CODE #12 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4034	OTHER PROCEDURE CODE #13 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4035	OTHER PROCEDURE CODE #14 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4036	OTHER PROCEDURE CODE #15 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4037	OTHER PROCEDURE CODE #16 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4038	OTHER PROCEDURE CODE #17 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4039	OTHER PROCEDURE CODE #18 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4040	OTHER PROCEDURE CODE #19 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4041	OTHER PROCEDURE CODE #20 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4042	OTHER PROCEDURE CODE #21 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4043	OTHER PROCEDURE CODE #22 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4044	OTHER PROCEDURE CODE #23 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4045	OTHER PROCEDURE CODE #24 IS INCOMPLETE AND REQUIRES ADDITIONAL INFORMATION
4046	THIS PROCEDURE IS NOT REIMBURSABLE IF PERFORMED BY A NON-PHYSICIAN MEDICAL PRACTITIONER
4047	MIPS PERCENTAGE APPLIED
4048	RAP CLAIM NOT FINALIZED
4049	FINAL HH CLAIM PAID
4050	INVALID PAYMENT STATUS FROM GROUPER
4051	NOT COVERED OR NOT COVERED UNDER OPPS
4052	FIRST LINE NOT ROOM & BOARD REVENUE CODE
4053	MODIFIER KX - PENALTY EXCEPTION
4054	NO CORRESPONDING RAP CLAIM
4055	COVID-19 LABORATORY ADD-ON CODE REPORTED WITHOUT REQUIRED PRIMARY PROCEDURE
4056	OPIOID TREATMENT PROGRAM SERVICE NOT PAYABLE OUTSIDE THE OPIOID TREATMENT PROGRAM
4057	CLAIM PREVIOUSLY DENIED WAS SUBMITTED TO NYDOH, PLEASE UPDATE DCN
4058	IDL - DIAGNOSIS CODE HAS BEEN DELETED
4059	FCS - CONSULTATION CODE IS REPORTED 1 DAY AFTER OTHER CONSULTATION CODE ON CLAIM
4060	OGF - ONLY 1 ONLINE DIGITAL E/M OR ASSESSMENT CODE MAY BE REPORTED BY THE SAME PROVIDER IN A 7 DAY PERIOD
4061	MUNAF - PER MEDICARE CCI GUIDELINES, PROCEDURE CODE HAS AN UNBUNDLE RELATIONSHIP WITH HISTORY PROCEDURE CODE
4062	MUNHAF - PER MEDICARE CCI GUIDELINES, HISTORY PROCEDURE CODE HAS AN UNBUNDLE RELATIONSHIP WITH THE PROCEDURE CODE
4063	MODF - USE OF MODIFIER(S) IS NOT TYPICAL FOR PROCEDURE CODE
4064	MFOM - PER MEDICARE GUIDELINES, IT IS INAPPROPRIATE TO REPORT MODIFIER FOR A PROCEDURE THAT IS DISCONTINUED ON A PROFESSIONAL CLAIM. THIS MODIFIER IS USED BY THE FACILITY TO INDICATE THAT A PROCEDURE WAS TERMINATED
4065	SFOM - MODIFIER IS INVALID FOR PROFESSIONAL CLAIM
4066	THMOF - FOR CLAIM LINES BILLING THERAPY ASSISTANT SERVICES, MODIFIER CQ MUST BE SUBMITTED WITH MODIFIER GP AND MODIFIER CO MUST BE SUBMITTED WITH MODIFIER GO
4067	112IOS - HCPCS CODE IS NON-COVERED AND IS FOR INFORMATIONAL REPORTING PURPOSES ONLY
4068	ISPF - HISTORY CLAIM IS FOUND IN THE PAID CLAIM HISTORY FOR THE SAME SNF PROVIDER WITHIN 3 CONSECUTIVE DAYS OF THIS READMISSION
4069	MEPO - PER MEDICARE GUIDELINES, EVALUATION AND MANAGEMENT CODE IS NOT COVERED WHEN REPORTED BY PROVIDER SPECIALTY CODE
4070	DRPC - THIS CLAIM LINE HAS A DUPLICATE RADIOLOGY PROCEDURE CODE ON A FACILITY CLAIM FOR THE SAME DATE OF SERVICE. THIS PROCEDURE CODE SUBMITTED SHOULD BE REVIEWED FOR POTENTIAL OVERPAYMENT
4071	PRCM - PROCEDURE CODE 99358 MAY NOT BE REPORTED WITH PROCEDURE CODE ON ANOTHER CLAIM IN THE SAME MONTH

4072	PRCMH - PROCEDURE CODE 99358 FOUND ON HISTORY CLAIM MAY NOT BE REPORTED IN THE SAME MONTH
4073	ABRCF - REVENUE CODE IS NOT ALLOWED ON TOB 012X A/B REBILL CLAIMS
4074	SBSL - PER MEDICAID GUIDELINES, BILATERAL PROCEDURE CODE MUST BE SUBMITTED ON SEPARATE CLAIM LINES
4075	MMNT - PER MEDICARE GUIDELINES, REASSESSMENT NUTRITION THERAPY CODE 97803 HAS BEEN BILLED WITHOUT THE INITIAL ASSESSMENT NUTRITION THERAPY CODE 97802 IN HISTORY
4076	MTMR - PER MEDICARE GUIDELINES, HCPCS CODE REQUIRES AN ADDITIONAL PROCEDURE CODE TO MEET THE CMS BILLING REQUIREMENTS
4077	ADIS - AMBULANCE SERVICES ARE NOT SEPARATELY PAYABLE WHEN REPORTED WITH A DATE OF SERVICE WITHIN AN ADMISSION AND DISCHARGE DATE OF AN INPATIENT CLAIM
4078	MPOC - PER MEDICARE GUIDELINES, PROCEDURE CODE 1 WITH MODIFIER 55 SUBMITTED ON CLAIM IS WITHIN THE GLOBAL PERIOD OF A PROCEDURE CODE FOUND IN A HISTORY ON CLAIM
4079	SPOC - PER MEDICAID GUIDELINES, PROCEDURE CODE WITH MODIFIER 55 SUBMITTED IS WITHIN THE GLOBAL PERIOD OF PROCEDURE CODE FOUND ON HISTORY CLAIM FOR THE SAME DATE OF SERVICE BY A DIFFERENT PROVIDER WITHOUT MODIFIER 54
4080	SRRD - PER MEDICAID GUIDELINES, PROCEDURE CODE SUBMITTED WITH PRIMARY DIAGNOSIS CODE QUALIFIES FOR A REDUCTION IN PAYMENT
4081	MPOH - PER MEDICARE GUIDELINES, PROCEDURE CODE WITHOUT MODIFIER 54 SUBMITTED IS WITHIN THE GLOBAL PERIOD OF PROCEDURE CODE FOUND ON HISTORY CLAIM FOR THE SAME DATE OF SERVICE BY A DIFFERENT PROVIDER WITH MODIFIER 55
4082	SPOH - PER MEDICAID GUIDELINES, PROCEDURE CODE WITHOUT MODIFIER 54 SUBMITTED IS WITHIN THE GLOBAL PERIOD OF PROCEDURE CODE FOUND ON HISTORY CLAIM FOR THE SAME DATE OF SERVICE BY A DIFFERENT PROVIDER WITH MODIFIER 55
4083	MHCS - PER MEDICARE GUIDELINES, HCPCS CODE G0472 IS NOT A COVERED SERVICE WHEN SUBMITTED WITHOUT ICD-10 CM CODE Z72.89 OR F19.20 FOR A MEDICARE BENEFICIARY BORN PRIOR TO 1945 OR AFTER 1965
4084	DLPC1 - A DUPLICATE LABORATORY PROCEDURE CODE IS REPORTED WITH MODIFIER 90. THE SAME LABORATORY PROCEDURE CODE IS REPORTED BY AN INDEPENDENT OR REFERENCE LABORATORY FOR THE SAME DATE OF SERVICE. ONLY ONE PROVIDER MAY REPORT A REFERENCE LAB PROCEDURE
4085	MKDE - PER MEDICARE GUIDELINES, PROCEDURE CODE HAS BEEN REPORTED WITHOUT THE APPROPRIATE ICD-10-CM DIAGNOSIS CODE N18.4
4086	TTOBF - PROCEDURE CODE TELEHEALTH SITE ORIGINATION FACILITY FEE, CANNOT BE BILLED ON THIS TYPE OF BILL
4087	MACO - PER MEDICARE GUIDELINES, PROCEDURE CODE REPORTED WITH MODIFIER SHOULD HAVE AN ADDITIONAL CLINICAL DECISION SUPPORT MECHANISM (CDSM) HCPCS CODE REPORTED FOR THE SAME DATE OF SERVICE
4088	DLPC1H - A DUPLICATE LABORATORY PROCEDURE CODE REPORTED WITH MODIFIER 90 IS FOUND ON HISTORY CLAIM FOR THE SAME DATE OF SERVICE. THE SAME LABORATORY PROCEDURE CODE IS REPORTED ON THE CURRENT LINE. ONLY ONE PROVIDER MAY REPORT A REFERENCE LAB PROCEDURE
4089	ESR4 - IT IS INAPPROPRIATE TO REPORT AN ESRD RELATED SERVICE CODE FOR HOME DIALYSIS (BASED ON PATIENTS AGE) MORE THAN ONCE PER MONTH
4090	MRAPF - MODIFIER KX CAN ONLY BE SUBMITTED ON REVENUE CODE 0023 ON A HOME HEALTH RAP CLAIM
4091	MWCA - PER MEDICARE GUIDELINES, HCPCS CODE REPORTED WITH MODIFIERS KU AND KE WILL BE DENIED
4092	MWC - PER MEDICARE GUIDELINES, PROCEDURE CODE REPORTED WITH MODIFIER KU SHOULD HAVE A MANUAL WHEELCHAIR HCPCS CODE REPORTED IN THE HISTORY FOR THE SAME PATIENT
4093	PHTS - A PROFESSIONAL HOME INFUSION THERAPY SERVICE MUST BE REPORTED BY SPECIALTY HOME INFUSION SUPPLIER (D6)
4094	PHTI - A PROFESSIONAL HOME INFUSION THERAPY SERVICES CODE ON HISTORY CLAIM WAS REPORTED WITHIN 60 DAYS OF AN INITIAL PROFESSIONAL HOME INFUSION THERAPY SERVICE CODE. IT IS NOT APPROPRIATE WITHIN 60 DAYS OF A PRIOR REPORTED HOME INFUSION THERAPY SERVICE
4095	113NAP - PRINCIPAL DIAGNOSIS CODE IS CONSIDERED SUPPLEMENTARY OR AN ADDITIONAL CODE AND CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS
4096	MWVS - PER MEDICARE GUIDELINES, HCPCS CODE G0439 REPORTED ON A PROFESSIONAL CLAIM IS NOT A COVERED SERVICE AS HCPCS CODE IS PREVIOUSLY REPORTED IN HISTORY WITHIN 12 MONTHS ON AN INSTITUTIONAL CLAIM
4097	114CSM - PROCEDURE CODE IS NOT ALLOWED WITH MODIFIER CS AS IT IS NOT ELIGIBLE FOR A COINSURANCE AND DEDUCTIBLE WAIVER
4098	HHODF - OSTEOPOROSIS DRUG HCPCS CODE MUST BE SUBMITTED ON TYPE OF BILL 034X FOR HOME HEALTH CLAIMS
4099	HHORF - OSTEOPOROSIS DRUG HCPCS CODE MUST BE SUBMITTED WITH REVENUE CODE 0636 FOR HOME HEALTH CLAIMS
4100	HHFDF - OSTEOPOROSIS DRUG HCPCS CODE CAN ONLY BE SUBMITTED FOR FEMALE BENEFICIARIES ON HOME HEALTH CLAIMS
4101	HHDMF - WHEN OSTEOPOROSIS DRUG HCPCS CODE IS SUBMITTED ON A HOME HEALTH CLAIM, DIAGNOSIS FOR POST-MENOPAUSAL OSTEOPOROSIS MUST BE PRESENT
4102	NPI OR FACILITY NOT SUPPLIED AND REQUIRED FOR LOOKUP
4103	ERROR READING CONFIGURATION RATE FILE
4104	ERROR READING HOSPITAL RATE CALCULATOR FILE
4105	ONE OR MORE RECORD(S) FOUND, RETURNED WITH AN ERROR DURING THE LOOKUP
4106	CLAIM AMOUNT HAS BEEN REDUCED DUE TO A PREVIOUS CLAIM
4107	OTHER PROCEDURE CODE #6 IS NOT VALID FOR DATE
4108	OTHER PROCEDURE CODE #7 IS NOT VALID FOR DATE
4109	OTHER PROCEDURE CODE #8 IS NOT VALID FOR DATE
4110	OTHER PROCEDURE CODE #9 IS NOT VALID FOR DATE
4111	OTHER PROCEDURE CODE #10 IS NOT VALID FOR DATE
4112	OTHER PROCEDURE CODE #11 IS NOT VALID FOR DATE
4113	OTHER PROCEDURE CODE #12 IS NOT VALID FOR DATE
4114	OTHER PROCEDURE CODE #13 IS NOT VALID FOR DATE
4115	OTHER PROCEDURE CODE #14 IS NOT VALID FOR DATE
4116	OTHER PROCEDURE CODE #15 IS NOT VALID FOR DATE
4117	OTHER PROCEDURE CODE #16 IS NOT VALID FOR DATE
4118	OTHER PROCEDURE CODE #17 IS NOT VALID FOR DATE
4119	OTHER PROCEDURE CODE #18 IS NOT VALID FOR DATE
4120	OTHER PROCEDURE CODE #19 IS NOT VALID FOR DATE
4121	OTHER PROCEDURE CODE #20 IS NOT VALID FOR DATE
4122	OTHER PROCEDURE CODE #21 IS NOT VALID FOR DATE
4123	OTHER PROCEDURE CODE #22 IS NOT VALID FOR DATE
4124	OTHER PROCEDURE CODE #23 IS NOT VALID FOR DATE

4125	OTHER PROCEDURE CODE #24 IS NOT VALID FOR DATE
4126	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #6
4127	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #7
4128	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #8
4129	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #9
4130	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #10
4131	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #11
4132	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #12
4133	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #13
4134	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #14
4135	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #15
4136	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #16
4137	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #17
4138	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #18
4139	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #19
4140	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #20
4141	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #21
4142	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #22
4143	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #23
4144	INVALID PATIENT SEX FOR OTHER PROCEDURE CODE #24
4145	NON-COVERED OTHER PROCEDURE CODE #6
4146	NON-COVERED OTHER PROCEDURE CODE #7
4147	NON-COVERED OTHER PROCEDURE CODE #8
4148	NON-COVERED OTHER PROCEDURE CODE #9
4149	NON-COVERED OTHER PROCEDURE CODE #10
4150	NON-COVERED OTHER PROCEDURE CODE #11
4151	NON-COVERED OTHER PROCEDURE CODE #12
4152	NON-COVERED OTHER PROCEDURE CODE #13
4153	NON-COVERED OTHER PROCEDURE CODE #14
4154	NON-COVERED OTHER PROCEDURE CODE #15
4155	NON-COVERED OTHER PROCEDURE CODE #16
4156	NON-COVERED OTHER PROCEDURE CODE #17
4157	NON-COVERED OTHER PROCEDURE CODE #18
4158	NON-COVERED OTHER PROCEDURE CODE #19
4159	NON-COVERED OTHER PROCEDURE CODE #20
4160	NON-COVERED OTHER PROCEDURE CODE #21
4161	NON-COVERED OTHER PROCEDURE CODE #22
4162	NON-COVERED OTHER PROCEDURE CODE #23
4163	NON-COVERED OTHER PROCEDURE CODE #24
4164	OPEN BIOPSY OTHER PROCEDURE CODE #6
4165	OPEN BIOPSY OTHER PROCEDURE CODE #7
4166	OPEN BIOPSY OTHER PROCEDURE CODE #8
4167	OPEN BIOPSY OTHER PROCEDURE CODE #9
4168	OPEN BIOPSY OTHER PROCEDURE CODE #10
4169	OPEN BIOPSY OTHER PROCEDURE CODE #11
4170	OPEN BIOPSY OTHER PROCEDURE CODE #12
4171	OPEN BIOPSY OTHER PROCEDURE CODE #13
4172	OPEN BIOPSY OTHER PROCEDURE CODE #14
4173	OPEN BIOPSY OTHER PROCEDURE CODE #15
4174	OPEN BIOPSY OTHER PROCEDURE CODE #16
4175	OPEN BIOPSY OTHER PROCEDURE CODE #17
4176	OPEN BIOPSY OTHER PROCEDURE CODE #18
4177	OPEN BIOPSY OTHER PROCEDURE CODE #19
4178	OPEN BIOPSY OTHER PROCEDURE CODE #20
4179	OPEN BIOPSY OTHER PROCEDURE CODE #21
4180	OPEN BIOPSY OTHER PROCEDURE CODE #22
4181	OPEN BIOPSY OTHER PROCEDURE CODE #23
4182	OPEN BIOPSY OTHER PROCEDURE CODE #24
4183	LIMITED COVERAGE OTHER PROCEDURE CODE #6
4184	LIMITED COVERAGE OTHER PROCEDURE CODE #7
4185	LIMITED COVERAGE OTHER PROCEDURE CODE #8
4186	LIMITED COVERAGE OTHER PROCEDURE CODE #9
4187	LIMITED COVERAGE OTHER PROCEDURE CODE #10
4188	LIMITED COVERAGE OTHER PROCEDURE CODE #11
4189	LIMITED COVERAGE OTHER PROCEDURE CODE #12
4190	LIMITED COVERAGE OTHER PROCEDURE CODE #13
4191	LIMITED COVERAGE OTHER PROCEDURE CODE #14
4192	LIMITED COVERAGE OTHER PROCEDURE CODE #15
4193	LIMITED COVERAGE OTHER PROCEDURE CODE #16
4194	LIMITED COVERAGE OTHER PROCEDURE CODE #17
4195	LIMITED COVERAGE OTHER PROCEDURE CODE #18
4196	LIMITED COVERAGE OTHER PROCEDURE CODE #19
4197	LIMITED COVERAGE OTHER PROCEDURE CODE #20
4198	LIMITED COVERAGE OTHER PROCEDURE CODE #21
4199	LIMITED COVERAGE OTHER PROCEDURE CODE #22
4200	LIMITED COVERAGE OTHER PROCEDURE CODE #23
4201	LIMITED COVERAGE OTHER PROCEDURE CODE #24
4202	BILATERAL OTHER PROCEDURE CODE #6
4203	BILATERAL OTHER PROCEDURE CODE #7
4204	BILATERAL OTHER PROCEDURE CODE #8
4205	BILATERAL OTHER PROCEDURE CODE #9
4206	BILATERAL OTHER PROCEDURE CODE #10
4207	BILATERAL OTHER PROCEDURE CODE #11
4208	BILATERAL OTHER PROCEDURE CODE #12
4209	BILATERAL OTHER PROCEDURE CODE #13
4210	BILATERAL OTHER PROCEDURE CODE #14
4211	BILATERAL OTHER PROCEDURE CODE #15
4212	BILATERAL OTHER PROCEDURE CODE #16
4213	BILATERAL OTHER PROCEDURE CODE #17

4214	BILATERAL OTHER PROCEDURE CODE #18
4215	BILATERAL OTHER PROCEDURE CODE #19
4216	BILATERAL OTHER PROCEDURE CODE #20
4217	BILATERAL OTHER PROCEDURE CODE #21
4218	BILATERAL OTHER PROCEDURE CODE #22
4219	BILATERAL OTHER PROCEDURE CODE #23
4220	BILATERAL OTHER PROCEDURE CODE #24
4221	SERVICE LINE IS A DUPLICATE OF ANOTHER LINE - MODIFIERS IGNORED
4222	CERTIFICATE ERROR
4223	INVALID URL
4224	ALL OTHER ERRORS RETURNED FROM GPCS
4225	INVALID CONTENT VERSION
4228	OPTUM ADJUSTED THE CLAIM PAYMENT INFORMATION FOR THIS CLAIM ON
4229	NEWBORN DOB IS REQUIRED
4230	NEWBORN GENDER IS REQUIRED
4231	NEWBORN BILLED WITH MOTHER
4232	CLAIM PAYMENT IS LIMITED BY LESSER OF ON LINE LEVEL
4233	051OBC - OBSERVATION HCPCS CODE G0378 CAN ONLY BE SUBMITTED ONCE PER CLAIM
4234	113NAPA - PRINCIPAL DIAGNOSIS CODE IS CONSIDERED SUPPLEMENTARY OR AN ADDITIONAL CODE AND CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS
4235	114CSMA - PROCEDURE IS NOT ALLOWED WITH MODIFIER CS AS IT IS NOT ELIGIBLE FOR A COINSURANCE AND DEDUCTIBLE WAIVER
4236	115CLA - COVID-19 LAB ADD-ON PROCEDURE CODE HAS BEEN SUBMITTED WITHOUT AN APPROPRIATE PRIMARY PROCEDURE CODE
4237	116OTP - PROCEDURE CODE IS FOR OPIOID TREATMENT PROGRAM AND CANNOT BE SUBMITTED ON THIS TYPE OF BILL
4238	117TCA - THE CHARGE AMOUNT FOR HCPCS CODE MUST BE EQUAL TO OR GREATER THAN $1.01
4239	ABPA - MEDICAL VISIT IS ON THE SAME DAY AS A PROCEDURE WITH A STATUS INDICATOR OF T OR S WITHOUT MODIFIER 25
4240	ABPAF - THE SERVICE DATE IS NOT WITHIN THE FROM AND THROUGH DATES OF SERVICE ON THE CLAIM
4241	ACOF - PER MEDICARE GUIDELINES, PROCEDURE CODE REPORTED WITH MODIFIER 2 SHOULD HAVE AN ADDITIONAL CLINICAL DECISION SUPPORT MECHANISM (CDSM) HCPCS CODE REPORTED FOR THE SAME DATE OF SERVICE
4242	CAGVAC - PROCEDURE INVALID PATIENT AGE
4243	CBPF - PER CMS GUIDELINES, BILATERAL PROCEDURE CODE 1 SHALL BE RETURNED WHEN SUBMITTED WITH MODIFIERS LT AND RT ON A CRITICAL ACCESS HOSPITAL (CAH) CLAIM UNDER REVENUE CODE 096X, 097X, OR 098X
4244	CDNAA - SEPARATE PAYMENT FOR PROCEDURE CODE IS NOT PROVIDED BY MEDICARE
4245	CDNAAF - SEPARATE PAYMENT FOR PROCEDURE CODE IS NOT PROVIDED BY MEDICARE
4246	CTPRF - PER CMS GUIDELINES, A REDUCTION SHOULD BE APPLIED TO HCPCS CODE WHEN MODIFIER CT IS APPENDED TO THE CLAIM LINE
4247	DIRF - THE SERVICE DATE IS NOT WITHIN THE FROM AND THROUGH DATES OF SERVICE ON THE CLAIM
4248	DLD - PROCEDURE CODE IS A DUPLICATE OF THE SAME PROCEDURE CODE PERFORMED BY A DIFFERENT PROVIDER FOR SPECIALTY AND DOS
4249	DLDB - PROCEDURE CODE IS A DUPLICATE OF THE SAME PROCEDURE CODE REPORTED BY A DIFFERENT PROVIDER, SAME GROUP, SAME SPECIALTY USING THE LT OR RT MODIFIER
4250	DLPCC - THIS CLAIM LINE HAS A POSSIBLE DUPLICATE PROCEDURE WITH PROFESSIONAL HISTORY CLAIM FOR THE SAME DATE OF SERVICE
4251	EDCC - THE CLAIM IS EXCLUDED FROM THE EDC ANALYZER
4252	EDCF - PROCEDURE CODE DOES NOT MEET THE CRITERIA FOR THE VISIT LEVEL SUBMITTED
4253	GCPT-THE CPT CODE BILLED WITH Z-CODE IS AN INVALID COMBINATION
4254	GCPTF - UNITS GREATER THAN ONE FOR BILATERAL PROCEDURE BILLED WITH MODIFIER 50
4255	GDUPL - DUPLICATE Z-CODE FOUND FOR THE SAME DATE OF SERVICE
4256	GDUPLF - UNITS GREATER THAN ONE FOR BILATERAL PROCEDURE BILLED WITH MODIFIER 50
4257	GDUPZ - DUPLICATE Z-CODE FOUND ON DATE OF SERVICE
4258	GDUPZF - PROCEDURE CODE IS NOT TYPICALLY PERFORMED IN AN ASC SETTING
4259	GFDA - FDA APPROVED OR LICENSED LAB KITS REQUIRE NPI TO BE REGISTERED TO THE PROVIDED Z-CODE
4260	GFDAF - HCPCS ADD-ON CODE IS LACKING A REQUIRED PRIMARY CODE ON THE CLAIM
4261	GIZC - MOLDX CPT CODE REQUIRES A VALID Z-CODE
4262	GIZCF - MOLDX CPT CODE REQUIRES A VALID Z-CODE
4263	ABPA - BILATERAL PROCEDURE CODE SHALL BE RETURNED WHEN SUBMITTED ON TWO CLAIM LINES WITH THE SAME DATE OF SERVICE AND BOTH LINES HAVE THE SAME MODIFIER RT OR LT
4264	GMULTI - MOLDX CPT CODES REQUIRE A SINGLE Z-CODE BE SUBMITTED
4265	GMULTIF - BILATERAL PROCEDURE CODE SHALL BE RETURNED WHEN SUBMITTED ON TWO CLAIM LINES WITH THE SAME DATE OF SERVICE AND BOTH LINES HAVE THE SAME MODIFIER RT OR LT
4266	GNCD - THE DIAGNOSIS CODE(S) SUBMITTED DOES NOT SUPPORT THIS COVERAGE FOR Z-CODE 1 AS STATED IN THE MOLDX TECHNICAL ASSESSMENT
4267	GNCDF - BILATERAL PROCEDURE CODE SHALL BE RETURNED WHEN SUBMITTED ON TWO CLAIM LINES WITH THE SAME DATE OF SERVICE AND BOTH LINES HAVE THE SAME MODIFIER RT OR LT
4268	GNCZ - THE DEX Z-CODE IS NOT COVERED PER THE MOLDX TECHNICAL ASSESSMENT
4269	GNCZF - BILATERAL PROCEDURE CODE 1 SHALL BE RETURNED WHEN SUBMITTED ON TWO CLAIM LINES WITH THE SAME DATE OF SERVICE AND BOTH LINES HAVE THE SAME MODIFIER RT OR LT
4270	GNPI - THE Z-CODE REQUIRES THE NPI TO BE REGISTERED WITH THE DEX DIAGNOSTICS EXCHANGE
4271	GNPIF - ADD-ON PROCEDURE CODE IS REPORTED WITH PRIMARY PROCEDURE CODE 23 THAT RECEIVED AN EDIT WITH A REVIEW OR DENY STATUS
4272	GZCR - MOLDX CPT CODES REQUIRE A Z-CODE TO BE SUBMITTED IN THE LINE LEVEL 2400 LOOP, SV101-7 ON ELECTRONIC CLAIMS
4273	GZCRF - THE CORNEAL TISSUE PROCESSING HCPCS CODE REQUIRES A CORNEAL TRANSPLANT PROCEDURE SUBMITTED ON THE SAME DATE OF SERVICE
4274	HDS - FREQUENCY LIMIT EXCEEDED. DISCHARGE 99238 AND/OR 99239 ALLOWED ONCE PER DOS
4275	HHDFF - THE ADMISSION, FROM, AND THROUGH DATES CANNOT BE A FUTURE DATE ON A HOME HEALTH NOA CLAIM
4276	HHDPF - PER MEDICARE GUIDELINES, OSTEOPOROSIS DRUG HCPCS CODE IS A POSSIBLE DUPLICATE OF ANOTHER OSTEOPOROSIS DRUG HCPCS CODE 2, ON HISTORY CLAIM ID 3, HISTORY LINE ID 4 FOR THE SAME DATE OF SERVICE
4277	HHMDF - FOR TYPE OF BILL 032A, THE ADMISSION, FROM AND THROUGH DATE MUST ALL MATCH
4278	HHOFF - PER CMS POLICY, OCCURRENCE CODE 50 MUST BE PRESENT ON A HOME HEALTH CLAIM TYPE OF BILL 032X

4279	HHRUF - PER MEDICARE GUIDELINES REVENUE CODE 0023 MUST BE SUBMITTED WITH UNITS GREATER THAN ZERO ON HOME HEALTH CLAIMS
4280	IDMR - PER ICD-10-CM GUIDELINES, DIAGNOSIS CODE IS ONLY FOR USE ON THE NEWBORN RECORD, NEVER ON THE MATERNAL RECORD
4281	IDNR - PER ICD-10-CM GUIDELINES, DIAGNOSIS CODE IS ONLY FOR USE ON THE MATERNAL RECORD, NEVER ON THE NEWBORN RECORD
4282	JEMDF - MODIFIER JE IS REQUIRED ON A DRUG ADMINISTERED VIA DIALYSATE WHEN SUBMITTED ON AN ESRD CLAIM (TYPE OF BILL 072X)
4283	M51 - PROCEDURE CODE 1 ON CLAIM ID 2, LINE ID 3 HAS BEEN BILLED ON THE SAME DOS AS ANOTHER PROCEDURE WITHOUT AN APPROPRIATE MODIFIER. TYPICALLY, PROCEDURES OR SERVICES WITH THE LOWER RELATIVE VALUE SHOULD BE REPORTED WITH MODIFIER 51
4284	M63AG - MODIFIER 63 WAS REPORTED WITH PROCEDURE CODE. MODIFIER 63 MAY ONLY BE REPORTED FOR INFANTS LESS THAN 1 YEAR OF AGE
4285	MAXNF - THE Z-CODE REQUIRES THE NPI TO BE REGISTERED WITH THE DEX DIAGNOSTICS EXCHANGE
4286	MGD - DELIVERY PROCEDURE CODE HAS BEEN REPORTED MULTIPLE TIMES ON CLAIM WITHOUT A DIAGNOSIS CODE FOR MULTIPLE GESTATION AND AN OUTCOME OF DELIVERY CODE FROM DIAGNOSIS CODE CATEGORY Z37
4287	MM51 - DENIED - MULTIPLE PROCEDURE MODIFIER REQUIRED
4288	MN51 - PER M/C GUIDELINES, PROCEDURE CODE 1 ON CLAIM ID 2, LINE ID 3 SUBMITTED WITH MODIFIER 51 IS INAPPROPRIATE. MODIFIER 51 SHOULD NOT BE APPENDED TO THE PROCEDURE CODE WITH THE HIGHEST RVU OR USE OF MODIFIER 51 IS NOT APPROPRIATE WITH PROCEDURE CODE
4289	MUEA - PER MEDICARES MEDICALLY UNLIKELY EDITS, THE UNITS OF SERVICE BILLED FOR PROCEDURE CODE EXCEED THE ALLOWED NUMBER OF UNITS OF 2
4290	MUEAF -PER MEDICARES MEDICALLY UNLIKELY EDITS, THE UNITS OF SERVICE BILLED FOR PROCEDURE CODE EXCEED THE ALLOWED NUMBER OF UNITS OF 2
4291	MWCF - PER MEDICARE GUIDELINES, PROCEDURE CODE REPORTED WITH MODIFIER KU SHOULD HAVE A MANUAL WHEELCHAIR HCPCS CODE REPORTED IN THE HISTORY FOR THE SAME PATIENT
4292	N51 - PROCEDURE CODE HAS BEEN BILLED WITH MODIFIER 51 ON A HISTORY CLAIM, EITHER THE PROCEDURE CODE HAS THE HIGHEST RVU ON THE CLAIM OR THE USE OF MODIFIER 51 IS NOT APPROPRIATE WITH THE PROCEDURE CODE
4293	NEF1I - THE CLAIM HAS AN INJURY DIAGNOSIS CODE(S) THAT IS CONSIDERED EMERGENT
4294	NEF2I - THE CLAIM HAS A PRINCIPAL DIAGNOSIS CODE THAT IS CONSIDERED EMERGENT
4295	NEF3I - THE CLAIM HAS A CPT CATEGORY TOTAL OF GREATER THAN 199 POINTS AND IS CONSIDERED EMERGENT
4296	NEF4I - THE CLAIM HAS CO-MORBIDITY DIAGNOSIS CODE(S) THAT IS CONSIDERED EMERGENT
4297	NEFAI - THIS ER CLAIM IS IDENTIFIED AS BEING NON EMERGENCY
4298	NEFAIC - THE CLAIM IS EXCLUDED FROM THE NON EMERGENT LOGIC
4299	NOTRF - A NOTICE OF ELECTION CLAIM MUST BE SUBMITTED PRIOR TO A NOTICE OF TERMINATION/REVOCATION CLAIM
4300	OGFH - ONLY 1 ONLINE DIGITAL E/M OR ASSESSMENT CODE MAY BE REPORTED BY THE SAME PROVIDER IN A 7-DAY PERIOD
4301	OTPAF - AN OPIOID TREATMENT PROGRAM ADD-ON PROCEDURE CODE HAS BEEN SUBMITTED WITHOUT AN APPROPRIATE PRIMARY PROCEDURE CODE
4302	OTPFF - PER MEDICARE, THE FREQUENCY DOES NOT MEET POLICY REQUIREMENTS FOR OPIOID TREATMENT PROGRAM (OTP) PROCEDURE CODE
4303	OTPSF - THE OPIOID TREATMENT PROGRAM (OPT) CLAIM IS MISSING A REQUIRED REVENUE CODE
4304	PRDA - PROCEDURE CODE SUBJECT TO A REDUCTION FOR ASSISTANT SURGEON MODIFIER AND WILL PAY AT 4 PERCENT
4305	PRDC - PROCEDURE CODE IS SUBJECT TO A REDUCTION FOR CO-SURGEON MODIFIER AND WILL PAY AT 4 PERCENT
4306	PRDT - PROCEDURE CODE IS SUBJECT TO A REDUCTION FOR SURGICAL TEAM MODIFIER AND WILL PAY AT 4 PERCENT
4307	RFXF - PER CMS GUIDELINES, MODIFIER FX OR FY IS ELIGIBLE FOR A REDUCTION WHEN BILLED ON AN IMAGING SERVICE
4308	RNM - INAPPROPRIATE USE OF A REPEAT PROCEDURE MODIFIER 76 OR 77 WITH A RADIOLOGY PROCEDURE CODE
4309	RXAGE - NATALIZUMAB, PROCEDURE CODE IS NOT APPROVED FOR THE PATIENTS AGE
4310	RXAGEF - NATALIZUMAB, PROCEDURE CODE IS NOT APPROVED FOR THE PATIENTS AGE
4311	RXCDX - TOCILIZUMAB, PROCEDURE CODE IS NOT COVERED FOR DIAGNOSIS CODE(S)
4312	RXCDXF - NATALIZUMAB, PROCEDURE CODE IS NOT COVERED FOR DIAGNOSIS CODE(S)
4313	RXDUP - NATALIZUMAB, PROCEDURE CODE WAS REPORTED WITHIN 21 DAYS OF A HISTORY PROCEDURE CODE LISTED AS A TREATMENT DUPLICATION BY THE FDA
4314	RXDUPF - NATALIZUMAB, PROCEDURE CODE WAS REPORTED WITHIN 21 DAYS OF A HISTORY PROCEDURE CODE LISTED AS A TREATMENT DUPLICATION BY THE FDA
4315	RXDXC - DIAGNOSIS CODE IS A CONTRAINDICATION FOR PEGFILGRASTIM PROCEDURE CODE
4316	RXDXCF - DIAGNOSIS CODE IS A CONTRAINDICATION FOR NATALIZUMAB PROCEDURE CODE
4317	RXFRQ - PER FDA GUIDELINES, FREQUENCY LIMITATIONS FOR PEGFILGRASTIM, PROCEDURE CODE HAVE BEEN EXCEEDED
4318	RXFRQF - PER FDA GUIDELINES, FREQUENCY LIMITATIONS FOR NATALIZUMAB PROCEDURE CODE HAVE BEEN EXCEEDED
4319	RXIDW - THE UNITS OF SERVICE BILLED FOR BOTOX PROCEDURE CODE SUBMITTED WITH MODIFIER JW EXCEEDS THE NUMBER OF UNITS ALLOWED
4320	RXIDWF - THE UNITS OF SERVICE BILLED FOR RITUXIMAB PROCEDURE CODE SUBMITTED WITH MODIFIER JW EXCEEDS THE NUMBER OF UNITS ALLOWED
4321	RXINDC - NDC CODE IS INVALID
4322	RXINDCF - NDC CODE IS INVALID
4323	RXMAX - THE NUMBER OF UNITS REPORTED FOR PEGFILGRASTIM, PROCEDURE CODE 1, EXCEEDS THE NUMBER OF UNITS ALLOWED
4324	RXMAXF - THE NUMBER OF UNITS REPORTED FOR BOTOX PROCEDURE CODE EXCEEDS THE NUMBER OF UNITS ALLOWED
4325	RXNDC - PROCEDURE CODE IS MISSING THE REQUIRED NDC
4326	RXNDCF - PROCEDURE CODE IS MISSING THE REQUIRED NDC
4327	RXTXC - NATALIZUMAB PROCEDURE CODE WAS REPORTED WITHIN 30 DAYS OF A HISTORY PROCEDURE CODE WHICH IS LISTED AS A TREATMENT CONTRAINDICATION BY THE FDA
4328	RXTXCF - NATALIZUMAB PROCEDURE CODE WAS REPORTED WITHIN 30 DAYS OF A HISTORY PROCEDURE CODE WHICH IS LISTED AS A TREATMENT CONTRAINDICATION BY THE FDA
4329	S51 - PROCEDURE CODE 1 IS AN ADD-ON CODE. MODIFIER 51 (MULTIPLE PROCEDURES) IS NOT APPROPRIATE WITH THE ADD-ON CODE ON CLAIM ID2, LINE ID 3

4330	SBPP - PER MEDICAID GUIDELINES, PROCEDURE CODE WITH MODIFIER EP AND HA IS NOT REIMBURSABLE WHEN THE SAME PROCEDURE CODE IS FOUND IN HISTORY WITH MODIFIER EP WITHIN A SPECIFIED PERIOD OF TIME
4331	SIPS - PER MEDICAID GUIDELINES, PROCEDURE CODE BILLED ON CLAIM IS INCORRECTLY SEQUENCED. THE ADMINISTRATION PROCEDURE CODE MUST BE SEQUENCED AFTER THE VACCINE PROCEDURE CODE. REVIEW MEDICAID POLICY FOR MORE DETAILS
4332	SM51 - PER MEDICAID GUIDELINES, PROCEDURE CODE ON CLAIM WAS SUBMITTED FOR THE SAME DOS AS ANOTHER PROCEDURE WITHOUT AN APPROPRIATE MODIFIER
4333	SMPN - PER MEDICAID GUIDELINES, THE ASSOCIATED ADMINISTRATION CODE FOR VACCINE PROCEDURE CODE IS MISSING OR INVALID
4334	SMUEA - PER MEDICAID MEDICALLY UNLIKELY EDITS, THE UNITS OF SERVICE BILLED FOR PROCEDURE CODE EXCEED THE ALLOWED NUMBER OF UNITS OF 2
4335	SMUEAF - PER MEDICAID MEDICALLY UNLIKELY EDITS, THE UNITS OF SERVICE BILLED FOR PROCEDURE CODE EXCEED THE ALLOWED NUMBER OF UNITS OF 2
4336	SN51 - PER MEDICAID GUIDELINES, PROCEDURE CODE ON CLAIM SUBMITTED WITH MODIFIER 51 IS INAPPROPRIATE
4337	SNPTH - PER MEDICAID GUIDELINES, NEW PATIENT E/M CODE FOUND IN HISTORY IS WITHIN THREE YEARS OF PROCEDURE CODE ON THE CURRENT LINE. AN ESTABLISHED PATIENT E/M CODE SHOULD BE REPORTED
4338	ITEM OR SERVICE NOT ALLOWED WITH MODIFIER CS
4339	SUPPLEMENTARY OR ADDITIONAL CODE NOT ALLOWED AS PRINCIPAL DIAGNOSIS
4340	AUTHORIZATION NOT REQUIRED DUE TO BILLED AMOUNT BELOW THRESHOLD
4341	CLAIM SERVICE PREVIOUSLY HAD A PAYER INITIATED (CR) ADJUSTMENT
4342	120MPT- INCORRECT REPORTING OF MODIFIER PT
4343	121NCI - NON-COVERED SERVICE REPORTED WITH INPATIENT ONLY PROCEDURE WHERE THE PATIENT EXPIRED OR TRANSFERRED
4344	122ADM - PASS-THROUGH DRUG AND BIOLOGICAL HCPCS CODE WITH A STATUS INDICATOR OF G, INCORRECTLY REPORTED WITH A 340B PROGRAM MODIFIER
4345	RXHNDC - NDC CODE IS INVALID FOR PROCEDURE CODE
4346	RXHNDCF - NDC CODE IS INVALID FOR PROCEDURE CODE
4347	RXMNDC -MISCELLANEOUS PROCEDURE CODE SUBMITTED WITH NDC CODE ON CLAIM CROSSWALKS TO A VALID HCPCS CODE THAT SHOULD BE REPORTED INSTEAD
4348	RXMNDCF - MISCELLANEOUS PROCEDURE CODE SUBMITTED WITH NDC CODE ON CLAIM CROSSWALKS TO A VALID HCPCS CODE THAT SHOULD BE REPORTED INSTEAD
4349	CARVE OUT PRICING APPLIED TO SERVICE LINE
4350	CARVE OUT PRICING APPLIED TO GROUPED CLAIM
4351	CARVE OUT PRICING ADDED TO SERVICE LINE
4352	SUPPLEMENTAL PAYMENT APPLIED
4353	MCWC - PER MEDICARE GUIDELINES, PROCEDURE CODE REPORTED WITH MODIFIER KU SHOULD HAVE A POWER OR MANUAL WHEELCHAIR HCPCS CODE REPORTED IN THE HISTORY FOR THE SAME PATIENT
4354	MIVA - PER MEDICARE GUIDELINES, ADMINISTRATION CODE BILLED FOR VACCINE CODE(S) IS NOT APPROPRIATE
4355	MPWC - PER MEDICARE GUIDELINES, PROCEDURE CODE REPORTED WITH MODIFIER KU SHOULD HAVE A POWER WHEELCHAIR HCPCS CODE REPORTED IN THE HISTORY FOR THE SAME PATIENT
4356	RXPAM0 - NO APPROVED AUTHORIZATION FOR THIS PATIENT AND DATE OF SERVICE
4357	RXPAM0F - NO APPROVED AUTHORIZATION FOR THIS PATIENT AND DATE OF SERVICE
4358	RXPAMA - AUTHORIZATION WAS OBTAINED FOR THIS SERVICE
4359	RXPAMC - AUTHORIZATION FOR PROCEDURE CODE NOT OBTAINED FOR DIAGNOSIS CODE
4360	RXPAMD - AUTHORIZATION WAS DENIED FOR THIS PATIENT FOR PROCEDURE CODE
4361	RXPAMDF - AUTHORIZATION WAS DENIED FOR THIS PATIENT FOR PROCEDURE CODE
4362	RXPAMPF - AUTHORIZATION FOR THIS PROCEDURE CODE NOT OBTAINED FOR SUBMITTED DIAGNOSES
4363	SMDF - SCREENING MAMMOGRAPHY CPT CODE REQUIRES THE APPROPRIATE DIAGNOSIS CODE
4364	20USC - DIAGNOSIS CODE IS AN UNSPECIFIED DIAGNOSIS CODE
4365	CCRCF - TYPE OF BILL REQUIRES AN APPROPRIATE CLAIM CHANGE REASON CODE
4366	DLDA - PROCEDURE CODE IS A POSSIBLE DUPLICATE OF THE SAME PROCEDURE CODE FOUND ON A HISTORY CLAIM REPORTED BY A DIFFERENT PROVIDER IN THE SAME GROUP AND SPECIALTY USING ANATOMIC MODIFIERS
4367	DLDAH - PROCEDURE CODE REPORTED WITHOUT AN ANATOMIC MODIFIER IN HISTORY, IS A POSSIBLE DUPLICATE OF THE CURRENT LINE REPORTED BY A DIFFERENT PROVIDER IN THE SAME GROUP AND SPECIALTY ON THE SAME DATE USING ANATOMIC MODIFIERS
4368	DLDG - PROCEDURE CODE IS A POSSIBLE DUPLICATE OF THE SAME PROCEDURE CODE FOUND ON A HISTORY CLAIM REPORTED BY A DIFFERENT PROVIDER IN THE SAME GROUP AND SPECIALTY USING MODIFIER GA, GC, GX, GY OR GZ
4369	DLDGH - PROCEDURE CODE REPORTED WITHOUT MODIFIER GA, GC, GX, GY OR GZ IN HISTORY, IS A POSSIBLE DUPLICATE OF THE CURRENT LINE REPORTED BY A DIFFERENT PROVIDER IN THE SAME GROUP AND SPECIALTY ON THE SAME DATE USING MODIFIER GA, GC, GX, GY OR GZ
4370	GMCRF - MOLECULAR GENETIC Z-CODE REQUIRES MEDICAL RECORD REVIEW
4371	GOB - PROCEDURE SUBMITTED INCLUDES PROF COMP MOD 26 AND TECH COMP MOD TC ON SEPARATE CLAIM LINES FOR THE SAME PROCEDURE, DOS AND PHYSICIAN. PLEASE REVIEW HISTORY AND CURRENT CLAIM LINES FOR THE PROCEDURE CODE TO REPORT AS A GLOBAL PROCEDURE CODE
4372	HHTBF - RAP TOB 0322 NO LONGER VALID FOR HOME HEALTH CLAIMS
4373	PROVIDER CONFIGURATION IS INVALID. SUBMITTING PROVIDER HAS TIN REFERENCE AND ALSO AN EXISTING AFFILIATION TO A PROVIDER WITH A TIN REFERENCE
4374	MONF - PER MEDICARE GUIDELINES, HCPCS CODE HAS EXCEEDED THE ALLOWED FREQUENCY. PAYMENT FOR HCPCS CODES G1028, G2215 OR G2216 IS LIMITED TO ONCE EVERY 30 DAYS UNLESS AN ADDITIONAL TAKE HOME SUPPLY OF THE MEDICATION IS MEDICALLY REASONABLE
4375	MSXF - PER MEDICARE GUIDELINES, PROCEDURE CODE IS A STATUTORY EXCLUSION FOR WHICH NO PAYMENT MAY BE MADE UNDER THE PHYSICIAN FEE SCHEDULE
4376	VCFDF - PER MEDICARE GUIDELINES, CLAIM RETURNED TO THE PROVIDER BECAUSE NO CHARGES ARE REPORTED FOR A MEDICAL DEVICE THAT RECEIVED FULL CREDIT OR WAS A NO COST DEVICE
4377	ERR - CES OTHER PROCESSING ERROR, SEE ADDITONAL ERRORS
4378	ERROR CREATING LOG FILE (EASYGROUP)
4379	NON-ZERO RETURN CODE FROM LOG CONTROL PROGRAM (EASYGROUP)
4380	NON-ZERO RETURN CODE FROM MEDICAID OUTPATIENT EDITOR (EASYGROUP)
4381	EXTENDED HOSPITAL RATE CALCULATOR RECORD NOT FOUND (EASYGROUP)
4382	ERROR READING CODE TABLE FILE (EASYGROUP)
4383	MMDA - G9891 IS REPORTED AND AN MDPP PAYABLE PERFORMANCE CODE IS NOT REPORTED ON THE SAME CLAIM
4384	MMDB - MDPP BRIDGE PAYMENT CODE IS BILLED AFTER OTHER MDPP CODE(S) BY THE SAME MDPP PROVIDER

4385	MMDI - SUBSEQUENT MDPP CODE IS BILLED AND THERE IS NO MDPP INITIAL CORE VISIT CODE OR BRIDGE PAYMENT CODE REPORTED IN HISTORY
4386	MMDN - THE EDIT IDENTIFIES CLAIM LINE(S) WHEN CPT CODE 90471 OR 90472 IS BILLED ALONG WITH A VACCINE CODE AND THE CORRESPONDING ADMINISTRATION HCPCS CODE G0008, G0009 OR G0010 IS MISSING
4387	MOD1 - CMS GUIDELINES REQUIRE THAT THE PROVIDER REPORT THE APPROPRIATE ORGAN OR DISEASE ORIENTED PANEL CODE AND NOT SEPARATELY REPORT THE INDIVIDUAL COMPONENT CODES THAT MAKE UP THAT PANEL CODE
4388	MOD2 - CMS GUIDELINES REQUIRE THAT THE PROVIDER REPORT THE APPROPRIATE ORGAN OR DISEASE ORIENTED PANEL CODE AND NOT SEPARATELY REPORT THE INDIVIDUAL COMPONENT CODES THAT MAKE UP THAT PANEL CODE
4389	MOD3 - CMS GUIDELINES REQUIRE THAT THE PROVIDER REPORT THE APPROPRIATE ORGAN OR DISEASE ORIENTED PANEL CODE AND NOT SEPARATELY REPORT THE INDIVIDUAL COMPONENT CODES THAT MAKE UP THAT PANEL CODE
4390	MOD4 - CMS GUIDELINES REQUIRE THAT THE PROVIDER REPORT THE APPROPRIATE ORGAN OR DISEASE ORIENTED PANEL CODE AND NOT SEPARATELY REPORT THE INDIVIDUAL COMPONENT CODES THAT MAKE UP THAT PANEL CODE
4391	MOD5 - CMS GUIDELINES REQUIRE THAT THE PROVIDER REPORT THE APPROPRIATE ORGAN OR DISEASE ORIENTED PANEL CODE AND NOT SEPARATELY REPORT THE INDIVIDUAL COMPONENT CODES THAT MAKE UP THAT PANEL CODE
4392	MOD6 - CMS GUIDELINES REQUIRE THAT THE PROVIDER REPORT THE APPROPRIATE ORGAN OR DISEASE ORIENTED PANEL CODE AND NOT SEPARATELY REPORT THE INDIVIDUAL COMPONENT CODES THAT MAKE UP THAT PANEL CODE
4393	MOD7 - CMS GUIDELINES REQUIRE THAT THE PROVIDER REPORT THE APPROPRIATE ORGAN OR DISEASE ORIENTED PANEL CODE AND NOT SEPARATELY REPORT THE INDIVIDUAL COMPONENT CODES THAT MAKE UP THAT PANEL CODE
4394	IRFHF - INPATIENT REHABILITATION FACILITY (IRF) CLAIMS, TOB 11X TO ENSURE REVENUE CODE 0024 IS SUBMITTED WITH A VALID HIPPS/CMG RATE CODE
4395	ESRRF - TOB 72X, WHEN VALUE CODES A8, PATIENT WEIGHT AND A9, PATIENT HEIGHT ARE NOT PRESENT
4396	IRSTF - TOB 11X WITH CONDITION CODE 40 - STATEMENT COVERED FROM AND THRU DATES ARE NOT THE SAME
4397	106AOP - SOFTWARE AS A SERVICE (SAAS) ADD-ON CODE - THE PRIMARY CODE IS MISSING
4398	IDCCF - THIS EDIT IDENTIFIES ICD-10-CM DIAGNOSIS CODES THAT ARE MUTUALLY EXCLUSIVE AND CANNOT BE REPORTED TOGETHER
4399	CODE FILE OPEN OR I/O ERROR (EASYGROUP)
4400	CCI EDIT FILE OPEN OR I/O ERROR (EASYGROUP)
4401	OCE/CCI EDIT FILE OPEN OR I/O ERROR (EASYGROUP)
4402	MUE FILE OPEN OR I/O ERROR (EASYGROUP)
4403	ERROR READING APC GROUPER FILE (EASYGROUP)
4404	UNSUPPORTED GROUPER VERSION (EASYGROUP)
4405	ERROR READING HHA PDGM READER FILE (EASYGROUP)
4406	INVALID OUTPATIENT CLASSIFICATION (EASYGROUP)
4407	CLAIM DOES NOT CONTAIN ANY PAYABLE SERVICES (EASYGROUP)
4408	INVALID HOME HEALTH/HOSPICE CLAIM DATES (EASYGROUP)
4409	CLAIM FROM DATE IS PRIOR TO HHA MEDICARE PARTICIPATION/CERTIFICATION (EASYGROUP)
4410	POSSIBLE LUPA CLAIM CONFLICT (EASYGROUP)
4411	CLAIM DOES NOT CONTAIN ANY PAYABLE SERVICES DUE TO UNTIMELY RAP/NOA SUBMISSION (EASYGROUP)
4412	INVALID HHA PEP CLAIM DATES (EASYGROUP)
4413	ERROR CALLING CALCULATION CONTROL PROGRAM (CALCCNTL:CLCCNTL)
4414	NON-ZERO RETURN CODE FROM CALCULATION CONTROL PROGRAM (CALCCNTL:CLCCNTL)
4415	ERROR READING PAYERS FILE (EASYGROUP)
4416	PROCEDURE CONSTRAINT MET FOR MEMBER
4417	TOOTH NUMBER IS REQUIRED FOR PROCEDURE CODE
4418	TOOTH SURFACE IS REQUIRED FOR PROCEDURE CODE
4419	ARCH/QUADRANT CODE REQUIRED FOR PROCEDURE CODE
4420	RENDERING PROVIDER REQUIRED FOR PROCEDURE CODE
4421	MBCF - PER MEDICARE GUIDELINES, PROCEDURE CODE IS A BUNDLE CODE FOR WHICH NO PAYMENT MAY BE MADE UNDER THE PHYSICIAN FEE SCHEDULE
4422	ABSS - THE CPT OR HCPCS CODE IS CONSIDERED BUNDLED TO THE AMBULANCE TRANSPORT SERVICE CODE REPORTED ON A HISTORY CLAIM. THE EQUIPMENT, SUPPLY, OR SERVICE IS NOT SEPARATELY PAYABLE WHEN REPORTED WITH AN AMBULANCE TRANSPORT CODE ON THE SAME DATE OF SERVICE
4423	ABSSH - AN EQUIPMENT, SUPPLY, AND/OR SERVICE HCPCS CODE ON A HISTORY CLAIM WAS REPORTED WITH AN AMBULANCE TRANSPORT CODE ON THE CURRENT CLAIM WITH SAME DOS AND PROVIDER. ONLY THE AMBULANCE TRANSPORT SERVICE MAY BE REPORTED, OTHERS ARE CONSIDERED BUNDLED
4424	MDO - PER MEDICARE GUIDELINES, UNIT(S) OF PROCEDURE CODE IS (ARE) ELIGIBLE FOR A 20% REDUCTION OF THE TECHNICAL COMPONENT FOR THE MULTIPLE DIAGNOSTIC OPHTHALMOLOGY SERVICES WHEN SUBMITTED BY THE SAME PROVIDER, FOR THE SAME PATIENT, FOR THE SAME DOS
4425	HHTRF - HOME HEALTH TELEHEALTH SERVICES MUST BE REPORTED WITH AN APPROPRIATE REVENUE CODE
4426	HHTTF - HOME HEALTH TELEHEALTH SERVICES MUST BE REPORTED WITH AN APPROPRIATE TYPE OF BILL
4427	125IMR - PROCEDURE CODE SHOULD NOT BE SUBMITTED WITH IMRT PLANNING CODE 77301
4428	MDOH - PER MEDICARE GUIDELINES, A 20% REDUCTION OF THE TECHNICAL COMPONENT MAY APPLY TO UNIT(S) OF A PROCEDURE CODE A IN HISTORY BY THE SAME PROVIDER INDICATES THAT MULTIPLE DIAGNOSTIC OPHTHALMOLOGY SERVICES WERE PERFORMED
4429	M53A - PER MEDICARE GUIDELINES, HOSPITALS SHOULD NOT REPORT MODIFIER 53
4430	M53F - PER MEDICARE GUIDELINES, HOSPITALS SHOULD NOT REPORT MODIFIER 53
4431	MAIM - PER MEDICARE GUIDELINES, WHEN AB MODIFIER IS REPORTED ON A CLAIM LINE, MODIFIERS TC AND OR 26 ARE INAPPROPRIATE FOR THE AUDIOLOGY SERVICE CODE
4432	126IRT - CODE SHOULD NOT BE SUBMITTED WITH A TELEHEALTH MODIFIER
4433	127NAB - SERVICE NOT ALLOWED FOR PART B INPATIENT CLAIM
4434	MAPS - PER MEDICARE GUIDELINES, THE PROVIDER SPECIALTY CODE IS INAPPROPRIATE FOR THE AUDIOLOGY SERVICE CODE WHEN BILLED WITH MODIFIER AB
4435	MEKG - PER MEDICARE GUIDELINES, MODIFIER 77 IS REQUIRED WITH CPT CODE 93010 AS A DIFFERENT PROVIDER ON HISTORY CLAIM LINE 1 REPORTED CPT CODE 93010 ON THE SAME DATE OF SERVICE IN PLACE OF SERVICE 23 WITHOUT MODIFIER 77 APPENDED
4436	IPERF - INPATIENT HISTORY CLAIM FOUND IN CLAIM HISTORY FOR THE SAME PROVIDER ON THE SAME DATE OF SERVICE

4437	DCHC - PROCEDURE IS A POSSIBLE DUPLICATE OF THE SAME PROCEDURE ON THE SAME DOS ON ANOTHER CLAIM. PROVIDERS THAT REASSIGNED THEIR BILLING TO THE CAH MAY NOT REPORT OUTPAT PROF SERVICES RENDERED IN THE CAH. REVIEW CLAIM FOR POTENTIAL DUPLICATE BILLING
4438	ONE OR MORE ADMISSION MOTOR SCORES OUT OF RANGE (EASYGROUP)
4439	INSUFFICIENT MEMORY (PRIOR TO APRIL 01, 2023) (EASYGROUP)
4440	GENERAL PROCESSING ERROR (PRIOR TO APRIL 01, 2023) (EASYGROUP)
4441	CODE LOOKUP ERROR, CODE NOT FOUND (EASYGROUP)
4442	ERROR OPENING EDITOR FILE(S) (EASYGROUP)
4443	ERROR READING EDITOR FILE(S) (EASYGROUP)
4444	ERROR CALLING ANALYZER CONTROL PROGRAM (CAACNTL) (EASYGROUP)
4445	NON-ZERO RETURN CODE FROM ANALYZER (EASYGROUP)
4446	NON-ZERO RETURN CODE FROM CAH METHOD II EDITOR (EASYGROUP)
4447	INVALID OR MISSING THRU DATE (EASYGROUP)
4448	RENDERING PROVIDER NOT FOUND
4449	NO AFFILIATION MATCHING RULE VALUE FOR DATE OF SERVICE
4450	SUBMITTING/RENDERING PROVIDER CONTRACT TYPES DO NOT MATCH
4451	MEMBER MUST HAVE ACTIVE ENROLLMENT WITH SUBMITTING AND RENDERING PROVIDER
4452	PROVIDER DOES NOT HAVE CONTRACT TYPE MATCHING MEMBER ENROLLMENT
4453	MDOC - THE EDIT IDENTIFIES CLAIM LINES WITH MODIFIER 22 APPENDED TO A PROCEDURE CODE
4454	SINF - HCPCS IS PACKAGED INTO PAYMENT FOR OTHER SERVICES UNDER THE OPPS. SEPARATE PAYMENT IS NOT MADE FOR STATUS INDICATOR OF N
4455	130IMI - INCORRECT REPORTING OF MODIFIER ON RHC IOP CLAIM
4456	132IOC - MENTAL HEALTH HCPCS CODE IS NOT APPROVED FOR AN INTENSIVE OUTPATIENT PROGRAM
4457	133IOB - MENTAL HEALTH SERVICE IS NOT PAYABLE OUTSIDE THE INTENSIVE OUTPATIENT PROGRAM
4458	134POP - THE SERVICE REPORTED WAS PROVIDED OUTSIDE OF THE PERIOD APPROVED BY CMS
4459	190IOP - AN INTENSIVE OUTPATIENT PROGRAM PRIMARY SERVICE IS NOT REPORTED FOR THE IOP CLAIM
4460	191PHP - PARTIAL HOSPITALIZATION PROGRAM PRIMARY SERVICE IS NOT REPORTED FOR THE PHP CLAIM
4461	AABF - PER MEDICARE, ONLY ONE AUDIOLOGY VISIT IS PERMITTED EVERY 12 MONTHS
4462	ADGF - ONLY ONE HOSPITAL INPATIENT OR OBSERVATION INCLUDING ADMISSION AND DISCHARGE SERVICE MAY BE REPORTED PER DAY
4463	CND - DIAGNOSIS CODE 1 IS NOT COVERED
4464	CNP - PROCEDURE CODE 1 IS NOT COVERED
4465	CNPD - PROCEDURE 1 AND DIAGNOSIS CODE 2 ARE NOT COVERED WHEN SUBMITTED TOGETHER
4466	CNPDF - PROCEDURE 1 AND DIAGNOSIS CODE 2 ARE NOT COVERED WHEN SUBMITTED TOGETHER
4467	CNPF - PROCEDURE CODE 1 IS NOT COVERED
4468	CNPM - PROCEDURE 1 AND MODIFIER CODE 2 ARE NOT COVERED WHEN SUBMITTED TOGETHER
4469	CNPMF - PROCEDURE 1 AND MODIFIER CODE 2 ARE NOT COVERED WHEN SUBMITTED TOGETHER
4470	ESM - IT IS NOT APPROPRIATE TO REPORT AN ESRD RELATED SERVICE CODE MORE THAN ONCE PER MONTH
4471	M25H - HCPCS CODE G2211 IS NOT PAYABLE WHEN EM CODE IS REPORTED WITH MODIFIER 25 APPENDED ON THE SAME DATE OF SERVICE BY THE SAME PROVIDER
4472	G2211 IS NOT PAYABLE WHEN BILLED ON THE SAME DOS AS E&M WITH MODIFIER 25 APPENDED
4473	MDC - HCPCS CODE Q2052 REQUIRES THE REPORTING OF INTRAVENOUS IMMUNE GLOBULIN J CODE ON THE DAY OF OR WITHIN 30 DAYS PRIOR TO ITS DATE OF SERVICE
4474	MDCH - MEDICARE DIABETES PREVENTION PROGRAM CODE G9888 REQUIRES THE REPORTING OF MDPP CODE G9880 PRIOR TO ITS DATE OF SERVICE
4475	MIVG - PER MEDICARE GUIDELINES, THE PATIENT DISCHARGE STATUS CODE 30 CANNOT BE USED WITH TOB
4476	MMD5 - THE WOUND SUCTION HCPCS MUST BE SUBMITTED WITH TYPE OF BILL 032X
4477	OOEMF - HCPCS CODE G2211 IN HISTORY IS NOT PAYABLE WHEN EM CODE REPORTED WITH MODIFIER 25 ON THE SAME DATE OF SERVICE BY THE SAME PROVIDER
4478	TOBWF - PER MEDICARE GUIDELINES REDUCTION OF THE TC MAY APPLY
7000	REVIEW CES FOR LOB SETUP
7003	PAID PER MC TARGETED RATE INCREASE POLICY
7250	ALLOWED AT AN ADDITIONAL 250% OF THE MCAL BASE
7350	ALLOWED AT AN ADDITIONAL 350% OF THE MCAL BASE
7905	ALLOWED AT AN ADDTIONAL 5% OF THE MCAL BASE
7910	ALLOWED AT AN ADDTIONAL 10% OF THE MCAL BASE
7923	ALLOWED AT AN ADDITIONAL 23% OF THE MCAL BASE
7925	ALLOWED AT AN ADDITIONAL 75% OF THE MCAL BASE
7930	ALLOWED AT AN ADDITIONAL 30%
7933	ALLOWED AT AN ADDITIONAL 33% OF THE MCAL BASE
7940	ALLOWED AT AN ADDITIONAL 40% OF THE MCAL BASE
7950	ALLOWED AT AN ADDITIONAL 50% OF THE MCAL BASE
7960	ALLOWED AT AN ADDITIONAL 60% OF THE MCAL BASE
7965	ALLOWED AT AN ADDITIONAL 65% OF THE MCAL BASE
7975	SPECIALTY PHYSICIAN REIMBURSEMENT 175% FS
7985	ALLOWED AT AN ADDITIONAL 85% OF THE MCAL BASE
8000	SUSPEND FOR DEVELOPMENT
8001	SERVICE APPROVED - CONVERSION
8002	SERVICE DENIED - CONVERSION
8003	STATISTICAL ADJUST OF SERV - CONVERSION
8004	PROCEDURE CODE IS NOT COVERED
8005	AUTHORIZATION REQD
8006	REFERRAL REQ'D
8007	MANUAL PRICING REQ'D
8008	MODIFIER REQUIRED
8009	INCLUDED IN OTHER PD SERVICE(S)
8010	MEMBER NOT FOUND IN SYSTEM / INVALID ID
8011	ACE 340B PRICING NOT FOUND
8012	PREMIUM NOT PAID - CLMS SUSPENDED
8013	PROC INVALID FOR MEMBER'S GENDER
8014	PROC INVALID FOR MEMBER'S AGE
8015	PYMT BUNDLED/INCLUDED IN OTHR SRVC
8016	INVALID PROCEDURE CODE
8017	PLEASE BILL HF TO MRMIB/HK TO COUNTY CCS
8018	AUTH ON FILE NOT FOR THIS PROC/MOD/NPI/DATE
8019	NAME & NPI OF FACILITY REQ FOR PRICING
8020	REJECTED CLAIM RETURNED
8021	DUPLICATE SERVICE LINE

8022	MOU ON FILE - MANUAL PRICING REQD
8023	CODE 1 RESTRICTION NOT MET
8024	PRICING REQD-CLAIM SUBJECT TO ER RATE
8025	MOD 51 EXEMPT FROM CUTBACK PRCNG REQ
8026	AUTHORIZATION REQUIRED
8027	INVALID DIAGNOSIS FOR PROC/ITEM BILLED
8028	SERVICE BUNDLE IN HIPPS PAYMENT
8029	MEDICARE PPS PRICING PERFORMED
8030	PLEASE PROVIDE ESRD-CMS RATE LETTER
8031	REV CODE REQUIRED
8032	ESRD CANNOT BE PRICED.CMS RATE LTR REQD
8033	AUTHORIZATION REQUIRED FOR RELATED SERVICE
8034	SERVICE LIMIT EXCEEDED
8035	PLS REBILL USING CORRECT LISTED CODES
8036	PLS PROVIDE TAXONOMY CODE
8037	POINT OF PICK UP REQUIRED FOR PRICING
8038	REDUCED BY 25% PER CMS GUIDELINES
8039	POSSIBLE MH EXCLUSION
8040	NOT PAYABLE UNTIL THE SOC HAS BEEN REPORTED
8041	INVALID CCS CONDITION
8042	SERVICES ARE COVERED UNDER MEDICARE FFS
8043	REVIEW FOR TAXONOMY
8044	RENDERING NUMBER REQUIRED OR INVALID
8045	RENDERING NUMBER REQUIRES REVIEW
8046	ORIGINALLY DENIED IN ERROR
8047	RETRACTED AS REQUESTED
8048	RETRO RATE ADJUSTMENT
8049	ADJUSTED BASED ON ADDITIONAL INFORMATION
8050	ADJUSTED BASED ON CORRECTED CLAIM
8051	DX ON CLAIM DOES NOT MATCH DX ON SAR
8052	DRG REQUIRES SEPARATE BILL FOR MOTHER & BABY
8053	INVALID BILL TYPE
8054	HOME HEALTH TAC AUTHORIZATION# REQUIRED
8055	AUTHORIZATION IS DENIED
8056	MSRP REQUIRED
8057	TAR REQUIRED FOR FACILITY
8058	MANUAL PRICING-PRICE ADULT RATE AGE 18 TO 21
8059	DIAGNOSIS INCONSISTENT WITH PATIENT GENDER
8060	PLEASE BILL WORKERS' COMP CARRIER
8061	REVIEW FOR POSSIBLE WORKERS' COMP
8062	VERIFICATION OF PROGRAM ELIGIBILITY REQD
8063	PREFERRED NETWORK PROV-APPLY 15% DISCOUNT
8064	SUBMITTED INFO DOES NOT SUPPORT UNBUNDLING
8065	BUNDLED-REDUCED BASED ON PREV PD CLAIM
8066	NOT COVERED BY HPSM-BILL ARGUS
8067	CCS-SUSPENDED FOR IP AUTHORIZATION
8068	REASON FOR VISIT DIAG IS REQUIRED
8069	APPLY 20% DISCOUNT - NON PREFERRED PROV
8070	PM330 FORM IS MISSING OR INCOMPLETE
8071	INVALID HCPCS/CPT/REVENUE CODE
8072	MEDICAL RECORDS REQUIRED FOR IP ADMISSION
8073	PRICE USING FQHC ALL INCLUSIVE RATE
8074	REIMBURSEMENT INCLUDED IN FQHC PPS
8075	DENIED-BILL MAGELLAN BEHAVIORAL HEALTH
8076	SEPARATE PAYMT IS NOT PROVIDED BY MEDICARE
8077	REQUIRED PRIMARY DX MISSING OR INVALID
8078	PROPOSITION 56 PAYMENT
8079	ACTUAL TIA NOT DOCUMENTED ON RECORDS
8080	CLAIM RQRD FOR EACH RENDERING PROVIDER
8081	SUP DOC DOES NOT MATCH BILLING CODE
8082	MED RECS DO NOT SUPPORT BILLING CODE
8083	ITEMIZATION AND/OR DOCS IS REQUIRED
8084	FREQUENCY/ MUE REVIEW
8085	REVIEW- HOPSICE MODIFIER
8086	MA SUPPLEMENTAL CLAIM
8087	J0882-REVIEW DOCS FOR MEDI-CAL FREQ
8088	DENIED-PLEASE SPECIFY NEWBORN INFORMATION
8098	INVALID AGE: REVIEW FOR BABY USING MOM'S ID
8099	SERVICE/ITEM REQUIRES REVIEW
8100	MODIFIER REQUIRES REVIEW / PRICING
8101	NOT A VALID MODIFIER ON DOS
8102	NOT A VALID CODE ON DOS
8103	FOR INPT DEDUCTIBLE
8104	MCRE/OHC PRIMARY,CLM PROCESSED AS SECONDARY
8105	PROV NOT ELIGIBLE TO BILL SERVICE / ITEM
8106	OHC/ICP/HIPP MEMBER. FURTHER REVIEW ON COVERAGE NEEDED
8107	RESTRICT AID CODE - SRVS NOT COVERED
8108	COVERAGE MAY BE AVAILABLE THROUGH CCS
8109	CONSENT FORM MISSING/INCOMPLETE
8110	PROVIDER SUBJECT TO MANUAL PRICING.
8111	NOT BILLABLE TO HPSM FOR DATE(S) OF SERV
8112	PART A DED/COINS PAYABLE TO CONT HOS ONLY
8113	NOT COVERED BY HPSM-BILL SAN MATEO BHRS
8114	BENEFIT AMT EXHAUSTED.NOT PAY W/O APP TAR
8115	SUSPEND FOR AUDITOR REVIEW
8116	DOCMNT NEEDED FOR SERVICE/ITEM BILLED
8117	PER MED REV DOCS NOT JUSTIFY PROC/SRV BILLED
8118	SOURCE/DESTINATION MISSING OR INVALID
8119	SERVICE/ITEM NOT PAYABLE THROUGH HPSM

8120	INPT CRITERIA NOT MET-REBILL OBSERV CODE
8121	SOC APPLIED
8122	SUSPEND PER VE EDIT
8123	DENIED PER VE EDIT
8124	INVOICE REQUIRED
8125	MISSING/INVALID PLACE OF SERVICE
8126	P4P INCENTIVE
8127	PRIMARY RA DOES NOT JUSTIFY PAYMENT FROM HPSM
8128	REPORTING PURPOSES ONLY
8129	MBR ID# BILLED DOES NOT MATCH MBR'S NAME
8130	MODIFIER MISSING OR INVALID/INCONSISTENT
8131	SAME SVC PREVIOUSLY PD TO ANOTHER PROV
8132	INCENTIVE PYBLE TO MBRS ASSIGNED PCP ONLY
8133	MUST BILL USING GROUP PROVIDER NUMBER
8134	REBILL W/EOMB IF MCAL PAYMENT IS EXPECTED
8135	MISSING OR INVALID NDC/UPN
8136	CLAIM MUST BE ITEMIZED
8137	PD UNDER CA VISION BENEFIT
8138	NON COVERED CONDITION
8139	INVALID/MISSING TIN
8140	HOME HEALTH PRICING PERFORMED
8141	NPI / ADDRESS MISMATCH
8142	PYMT SUBJECT TO DOCUMENT REQMTS PER MEDICARE
8143	PROVIDER NOT CERTIFIED TO PERFORM PROCEDURE
8144	ONLY ONE VISIT IS ALLOWED PER DAY
8145	E&M VISIT DISALLOWED ON SAME DOS AS SURG
8146	OFFICE VISIT IS WITHIN SURG PRE-OP
8147	OFFICE VISIT IS WITHIN SURG POST-OP
8148	ADD-ON PROC DISALLOWED W/OUT PRIMARY PROC
8149	REQUIRED PRESENT ON ADMISSION INDICATOR MISSING
8150	INVALID POS FOR ITEM/SERVICE BILLED
8151	PROFESSIONAL COMPONENT IS NOT REIMBURSABLE
8152	MBR HAS OTHER CVRG-CA IS SECONDARY
8153	PREVENTABLE CONDITION REPORTED-$0 DUE
8154	DIALYSIS CLAIM
8155	PROCEDURE CODE HAS BEEN DELETED
8156	ANOTHER CODE IS AVAILABLE
8157	SVCS DURING HOSPICE NOT PAYABLE BY HPSM
8158	UNITS BILLED DO NOT MATCH MEDICAL RECORDS
8159	VERIFICATION OF PCP ASSIGNMENT
8160	UPN IS INVALID
8161	2% REDUCTION FEDERAL BUDGET SEQUESTRATION
8162	CONSENT FORM MISSING OR INCOMPLETE
8163	HIPPS CODE REQUIRED
8164	ONE CLAIM REQUIRED FOR MOM & BABY
8165	RUGS CODE REQUIRED
8166	CONFIRM ELIGIBILITY AS A BILLING PROVIDER
8167	REVIEW - POSSIBLE HOSPICE
8168	DIAGNOSIS COVERED UNDER HOSPICE
8169	BIRTHWEIGHT REQUIRED BY AN ICD-9-CM DX CODE
8170	PROCEDURE NOT PAYABLE TO ASSISTANT SURGEON
8171	ID# CORRECTED, PLEASE VALIDATE YOUR RECORDS
8172	NO RATES, SEND MEDICARE LEGACY# ASSOC W/NPI
8173	INVALID NPI BILLED
8174	SERVICE MUST BE BILLED WITH MULTIPLE UNITS
8175	CCS AUTHORIZATION IS REQUIRED
8176	FWD'D TO HS TO REQUEST MED RECORDS
8177	CRITICAL CARE HOSP - MANUAL PRICING REQD
8178	VISIT NOT DONE IN THE FIRST TRIMESTER
8179	MULTIPLE PROCEDURE REDUCTION APPLIES
8180	NOT COVERED BY HPSM-BILL MEDI-CAL FFS
8181	INVALID / MISSING TIN
8182	BUNDLED WITH IP STAY-BILL HOSPITAL
8183	CHDP BILLING INVALID FOR PLAN
8184	$0 REIMBURSEMENT PER SM COUNTY AGREEMENT
8185	REVIEW FOR REQUIRED DOCUMENTATION OR REMARK
8186	AUTH SENT FOR CORRECTION
8187	PLEASE REBILL USING CLAIM FORM UB04
8188	PLEASE PROVIDE AQUISITION COST
8189	PRICING MODIFIER MUST BE IN THE 1ST POSITION
8190	BLUESHEET TO PR/CONFIG
8191	DENIED - A PORTION OF THIS STAY WAS PREVIOUSLY DENIED BY HPSM. REBILL COVERED DAYS ONLY
8192	MANUAL PRICING PER AB 72 REQ'D
8193	MEDICAL RECORDS/INPATIENT NOTIFICATION REQUIRED FOR THIS IP STAY. FAX TO 650 829 2062
8194	VERIFY SOC AMOUNT REPORTED ON THE CLAIM
8195	OCCURRENCE CODE REQUIRED
8196	PLS REBILL USING CORRECT BILLING GUIDELINE
8197	VERISK REVIEW REQUIRED
8198	MUST USE ALTERNATE HS PROV#-SEE PROVIDER COMMENT
8199	MUST USE HS PROV# 23048
8200	LEVEL OF CARE REVIEW REQUIRED
8201	REIMBURSEMENT REDUCED PER MODIFIER
8202	RESUBMIT USING APPROPRIATE FORM
8203	CLAIM SPANS 2 CALENDAR YEARS. PLS SPLIT BILL
8204	INVOICE AND MSRP REQUIRED
8205	WEBSTRAT MANUAL PRICING REQUIRED
8206	DIAGNOSIS INCONSISTENT WITH PATIENT AGE
8207	MISSING/INCOMPLETE/INVALID REMARKS-REBILL
8208	OPTIONAL BENEFIT EXCLUSION-PROC NOT COVERED

8209	REVIEW MEDI-CAL OPTIONAL BENEFITS
8210	REVIEW FOR HK CO-PAY
8211	PROC DOES NOT SUPPORT COMPONENT MOD BILLED
8212	COBA COX- REVIEW ELIGIBILTY / LOB
8213	MISSING/INCOMPLETE/INVALID CONDITION CODE
8214	REVIEW MULTIPLE VISITS-CONDITION CODE G0
8215	REVENUE CODE CANNOT BE SUBMITTED W/ TOB 22X
8216	SNF PDPM BILLING DATE REQUIRE REVIEW
8217	DEDUCT FWD'D TO MEDICAL. DO NOT BALANCE BILL
8218	COINS FWD'D TO MEDICAL. DO NOT BALANCE BILL
8219	COPAY FWD'D TO MEDICAL. DO NOT BALANCE BILL
8220	CHECK FFS MEDI-CAL FOR PRIMARY COVERAGE
8221	TYPE OF BILL INCONSISTENT W ADMISSION DATE
8222	PRICED BY REPORT CODE (DME)
8223	REVIEW MEMBER INFORMATION
8224	PAMF CHARITY CARE PARTICIPANT
8225	COVID-19 POLICY TK 193437
8226	PROC DATE MUST BE WITHIN STATEMENT DATE
8227	DENIED-PENDING TAS APPROVAL
8228	FQHC PPS (PAYMENT CODE) IS MISSING
8229	REVIEW SUBMITTED UPN/ NDC # ON CLAIM IMAGE
8230	CODE NOT SEPARATELY PAYABLE PER AGREEMENT
8231	PRICED BY REPORT CODE (MEDICAL SUPPLY)
8232	ACES TRAINING REQUIRED
8233	DOCUMENTATION IS INCOMPLETE/INVALID
8234	COB REVIEW -IP CLAIM WITH PART B COVERAGE
8235	REVIEW MEDICARE DENIAL REASON
8236	COBA/XOVER E CLAIM - CLAIM REVIEW NEEDED
8237	COBA CLAIM LOADED TO CA - REVIEW NEEDED
8238	SENT TO PHARMACY FOR PRICING
8239	HOSPICE MANAULLY PRICED
8240	ADMIT AND DISCHARGE SAME DAY-REBILLOP CLM
8241	SBMTD DISCHARGE STATUS IS INVALID
8242	NO W9 ON FILE WITH HPSM-REVIEW REQ'D
8243	PLS REBILL W/ CORRECT NPI FOR BLD SERVICE
8244	REVIEW HEALTHWORX MSP POLICY FOR COB
8245	NON-PHYSICIAN RENDERING REVIEW NEEDED
8246	J2326 REVIEW INTERNAL JOB AID/MEDI-CAL POLICY
8247	MISSING PRIOR HOSPITAL DISCHARGE DATE
8248	REVIEW ALL LINES-RELATED TO CONSENT FORM
8249	DENIED-FEDERALLY PURCHASED COVID VACCINE
8250	ADJUSTMENT-DHCS LTC SETTLEMENT WITH SMMC
8251	LTC QUALITY INCENTIVE PAYMENT INCLUDED
8252	NOT COVERED FOR THIS PROVIDER TYPE
8253	SUSPENDING-PDR REVIEW AND HANDLING
8254	PENDING CATALYST REVIEW
8255	TOB VOID REQUEST Â€“ REVIEW POLICY
8256	REVIEW ENTRY OF POS-FIX OR DENY 8125
8257	FORWADED TO RESEARCH/REPORT OHC TO DHCS
8258	REVIEW AND VALIDATE 1377 EDIT(S)
8259	CLM RECOVERED PER COORDINATION OF BENEFITS
8260	REVIEW CM 8004 AGAINST AUTH ON FILE
8261	REVIEW K0108 AGAINST CMS LCD L33792
8262	REVIEW PROVIDER - MISSING ADDRESS
8263	AUTHORIZATION AMOUNT EXHAUSTED
8264	REFER TO SHIELD HEALTHCARE AGREEMENT
8265	REVIEW SUBMITTED DX ON CLAIM IMAGE
8266	REVIEW GENDER PROVIDER FOR MOU ON FILE
8267	BY REPORT - VISION CODE
8268	ORTHO IMPLANT-SEE STANFORD CONTRACT REIMB
8269	NOT VALID FOR MEDICARE PURPOSES
8270	PROFEE SERVICES BILLED BY FACILITY-REVIEW
8271	DENIED - TOOTH SURFACE REQUIRED/INVALID
8272	DENIED - TOOTH NUMBER REQUIRED/INVALID
8273	DENIED - ARCH/QUADRANT CODE REQUIRED/INVALID
8274	DENIED - ORAL CAVITY CODE REQUIRED/INVALID
8275	PRICING REQÂ€™D-NON-MC EMG PROVIDER POLICY
8276	PROC IS LIMITED TO 1 EVERY 6 MOS PER PROV
8277	PROC IS LIMITED TO ONE PER PATIENT PER PROV
8278	PROCEDURE IS LIMITED TO 6 IN THREE MONTHS
8279	PROCEDURE IS LIMITED TO 12 IN 12 MONTHS
8280	SERVICES ARE LIMITED TO ONCE EVERY 36 MOS
8281	PERIAPICALS LIMITED TO 20 IN A 12 MO PERIOD
8282	SERVICES ARE LIMITED TO TWICE EVERY 6 MOS
8283	SERVICES ARE LIMITED TO ONCE EVERY 6 MOS
8284	SVCS ARE LIMITED TO TWICE EVERY 12 MOS
8285	SVC ARE LIMITED TO 1 PER TOOTH EVERY 36 MOS
8286	PROCEDURE IS LIMITED TO ONCE PER QUADRANT
8287	SERVICES ARE LIMITED TO ONCE EVERY 12 MOS
8288	SVCS ARE LIMITED TO 1 PER TOOTH EVERY 6 MOS
8289	SVC LIMITED TO TWICE PER ARCH EVERY 12 MOS
8290	DENTAL ORTHO - REVIEW CDDP FOR GUIDANCE
8291	LAB BILLED WITH MOD 26 - SEE PHYSICIAN FS
8292	UNITS REDUCED TO MATCH RELATED PAID CODES
8293	INVOICE /MSRP IS INVALID
8294	CLAIM ADJ/REDUCED PER CATALYST
8295	CONFIRMED NOT A DUPLICATE CLAIM
8296	REBILL ON SEPARATE CLAIM LINES-PER TOOTH
8297	REVIEW FOR POSSIBLE ORGAN PROCUREMENT

8298	REASON FOR VISIT MUST NOT BEGIN V,W,X OR Y
8299	PROPOSITION 56 DENTAL PAYMENT
8300	CHECK ADMIT DATE FOR MEDI-CAL COVERAGE
8301	PENDING FOR BUNDLING REVIEW- STATUS T CODE
8302	REVIEW ELECTRONIC OHC INFORMATION
8303	DATE OF DEATH PRECEDES THE DATE OF SERVICE
8304	REIMBURSED BASED ON LTC RATE
8305	REIMBURSED BASED ON LTC FACILITY RATE
8306	NF QUALITY PAYMENT PROGRAM ANNUAL LUMP SUM
8307	CONTINUITY OF CARE INCENTIVE PAYMENT
8308	MANUAL APPLICATION OF CO-INS-SEE POLICY
8309	VALIDATE PRIMARY INSURANCE COVERAGE
8310	PROC IS LIMITED TO 1 EVERY THREE MONTH
8311	MISSIN/INCOMPLETE/INVALID POINT OF DROP-OFF
8312	CLAIM VOIDED PER PROVIDER REQUEST
8313	PCP CAP -SUPPLEMENTAL PAYMENT
8314	REVIEW LTC PART B PROCESSING
8315	MISSING/INVALID DIAGNOSIS CODE
8316	MISSING/INCOMPLETE VALUE CODE OR AMOUNT
8317	MISSING PRINCIPAL/OTHER PROCEDURE CODE
8318	REVIEW LTC PART A PROCESSING
8319	REQUIRED PRIMARY DX MISSING OR INVALID
8320	PROVIDER UNDER REVIEW
8321	DMR-REQ FOR ADDTL INFO LETTER ISSUED
8322	SRVC LIMITED TO ONCE IN 24 MONTHS
8323	INVALID MODIFIER - MODIFIER AG IS ALLOWED ONCE PER OPERATIVE SESSION
8324	MANUAL PRICING REQ'D FOR FREQUENCY CUTBACK
8325	CES FLAG NOT YET MAPPED TO HS - REVIEW OTHER ERROR AND CES APP
8326	POSSIBLE TRANSPLANT CLAIM-REVIEW
8327	WORLDWIDE EMERGENCY COVERAGE
8328	REVIEW MODIFIER 99 CDDP
8329	REVIEW COINSURANCE, COPAY AMOUNT
8330	MODIFIER IS NOT RECOGNIZED BY CAREADVANTAGE/MEDICARE. REBILL WITH MEDICARE MODIFIER
8331	HIGH COST DRUG REQUIRES MANUAL PRICING - SEE CDDP/PROVIDER CONTRACT
8400	ONE TIME EXCEPTION TO PAY W/O PRIOR AUTH
8401	GEMT PAYMENT PER QAF PROGRAM
8402	CLAIM REFERRED TO CATALYST
8403	LTC COMMUNITY PLACEMENT INCENTIVE PAYMENT
8404	CHECK FOR ACE REFERRAL
8405	MISSING DISCHARGE HOUR
8406	MISSING/INCOMPLETE/INVALID POINT OF PICK UP
8501	FULL RETRACTION,CLAIM TO BE REPROCESSED
8502	PYMNT REDUCED TO EST PT DUE TO PREV NEW VST
8503	INVALID CONDITION CODE - SEE PLAN RQMNTS
8504	LEVEL OF CARE UPDATED TO MATCH AUTHORIZATION
8505	MISSING/INVALID DAYS OR UNITS OF SERVICE
8506	SERVICE INCLUDED IN CASE RATE
8507	UNIT MAXIMUM HAS BEEN REACHED
8508	BUNDLED/MUTUALLY EXCLUSIVE TO ANOTHER SRVC
8509	SERVICE DOES NOT MEET CRITERIA FOR INCENTIVE
8510	MISSING/INVALID PROVIDER SIGNATURE
8511	P4P CODE CAPTURED FOR REPORTING PURPOSE ONLY
8512	NOT PAYABLE UNTIL SOC HAS BEEN REPORTED
8513	AUTH AND DESK PROCEDURE REVIEW REQD
8514	COVID INCENTIVE PROGRAM
8515	MAXIMUM OUT OF POCKET REACHED
8879	BENEFIT REQUIRES APPROVAL
8880	NO W9 ON FILE WITH HPSM - REVIEW REQ'D
8881	MEMBER ON REVIEW
8882	DENIED-AWAITING W9 PER MAILED REQUEST
8883	PAYMENT REDUCED TO AUTHORIZED AMOUNT
8884	MEDICAL RECORDS FORWARDED TO HS FOR REVIEW
8887	ADJUSTMENT FOR ACA PRIMARY CARE INCENTIVE
8888	SUSPEND FOR INTERNAL REVIEW
8889	DENIED-PROVIDER PRECLUDED FROM PAYMENT
8969	PENDING ROUTINE RATE UPDATE
8970	REBILL UNDER CORRECT AUTH NUMBER
8974	SDP TICKET SUBMITTED TO IT CONFIG
8975	SEE PROVIDER AGREEMENT
8976	CLAIM BEING RESEARCHED
8977	ADMITTING DX REQUIRED
8978	CLINICAL TRIAL RESP OF FFS MCARE-REVIEW
8979	DEVELOPMENT VERIFIED
8980	TOB REQUIRES REVIEW
8981	REFERRAL REQ'D
8982	PLS REBILL ON LTC 25-1 & LTC ACCOM CODES
8983	ACE SNF CLAIM - SUBJECT TO 30-DAY MAX
8984	MCE PAID AT ZERO
8985	CMS PRIMARY CARE INCENTIVE PAYMENT
8986	CMS E-PRESCRIBING BONUS PAYMENT
8987	CMS PHY QUALITY REPORTING INITIATIVE PYMT
8988	CAPITATED SRVC RENDERED BY ON CALL
8989	SUSPEND FOR POSSIBLE SED COVERAGE
8990	MCRE PRIMARY,CLM PROCESSED AS SECONDARY
8991	CHDP PROCESSING APPLIED TO CLAIM
8992	MCE ER SRVC PAY @ 30% OF MC RATE
8993	PAYABLE USING ACE PPS RATE
8994	MEMBER UNDER HOSPICE, BILL FFS MEDICARE
8995	DENIED-SERVICE RENDERED TO A DIFFERENT PT

8996	CAPITATED SERVICE - BILL KAISER
8997	VE OVERRIDE
8998	CAPITATED SERVICE
8999	FORCE SUSPEND