Appendix R

Remittance Advice Messages

Edit Number	Description
0000	This claim/service is pending for program review.
0007	Information inadequate to establish medical necessity of procedure performed. Please resubmit with additional supporting documentation.
0010	The number of hospital visits exceeds the guidelines for the procedure billed.
0030	EPSDT services are not a benefit with office visits.
0039	The National Drug Code (NDC) is missing. The NDC is required for physician-administered drugs. Please reference the provider billing manuals and the following bulletins for more information: December 2007 #B070024, June 2008 #B0800249, May 2009 #B0900266.
0044	The provider is not authorized to perform or provide the service requested.
0067	The claim dates of service overlap the ICD version effective date. No overlap is allowed between ICD9 and ICD10. Claim must be split.
0074	Billing Provider is restricted from submitting electronic claims.
0091	A valid enrolled prescribing/referring/ordering provider NPI is required.
0100	Denied as duplicate claim. Services on this claim were previously partially paid or paid in full.
0101	This is a duplicate service.
0103	This is a duplicate item that was previously processed and paid, possibly to another provider.
0110	There is no additional benefit for this service. Payment for this procedure was included in the payment for the primary procedure.
0115	Unable To Process Your Adjustment Request.
0116	Procedure Code or Drug Code not a benefit on Date of Service.
129	The member's State ID number is missing. Enter the member's State ID number listed on the eligibility inquiry.
0140	A new member Nursing Facility (NF) visit is limited to one. A new NF visit was previously paid to this provider. Bill the appropriate established member c
0150	Place of Service is Missing or Invalid
0162	The service is included in the FQHC/ RHC encounter rate. This service is not a separate benefit.
0165	The Medicare provider number is missing or invalid. Enter/Correct the Medicare provider number.
0169	The Medicare paid amount is missing or invalid. Enter/Correct the amount paid by Medicare as it appears on the Medicare explanation of benefits.
0181	The 1st condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
0182	Billing Provider Type and/or Specialty is not allowable for the service billed.
0185	Procedure Code billed is not appropriate for the member's gender.

Edit Number	Description
0192	Prior Authorization (PA) is required for this service. An approved PA was not found matching the provider, member, and service information on the claim.
0193	The 2nd Occurrence Span code is invalid. Correct the 2nd occurrence span code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
0212	The 1st Occurrence Span Code Invalid. Correct the first occurrence span code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
0222	Claim Currently Being Processed. No Action on Your Part Required.
0240	The line was denied by Medicare. If the service is not a Medicare benefit, it can be billed as a Medicaid claim.
0248	The birth date does not match member's State ID number. Correct the birth date/State ID number. If billing for newborn care with the mothers DOB and StateID number for DOS after 11/30/2003 use modifier UK. If billing prior to 11/30/003 use modifier XN.
0250	Pap smears are limited to one per year. One routine Pap smear was paid during this 12-month period. Additional Pap smears must be billed with a diagnosis code justifying the additional tests.
0254	Accommodation Days Missing/Invalid. Please correct and resubmit.
0260	The OB services are billed incorrectly. Refer to the OB billing instructions in the Provider Manual.
0272	The Admit Date on the claim is prior to the member's Date of Birth. Re-submit claim with an Admit Date equal to or greater than the member's Date of Birth.
0273	Claim DRG indicates newborn. Member age is greater than three years and is not considered a newborn
0275	Adjustment/reconsideration Request Denied Due To Incorrect/insufficient Information. Review Billing Instructions. Use This Claim Number If You Resubmit.
0280	Only one collection fee is allowed per day. One was paid previously for this date of service.
0288	The Revenue/HCPCS Code combination is invalid.
0302	The attending provider number is not on file. Verify the 8-digit Medicaid provider number of the other provider.
0310	Counseling is not a benefit with EPSDT screening. Counseling is included in the screening charge.
0352	The billing provider number is not on file.
0364	Procedure Code/Tooth Number Conflict - Tooth number on claim is not valid with the submitted procedure code. Please correct and resubmit your claim.
0381	Records indicate this tooth has previously been extracted. Correct claim or resubmit with x-ray.
0389	Header From Date of Service is required. Enter the From Date of Service.
0393	The revenue code and procedure code are in conflict. Please verify whether a HCPC can be used with this revenue code and ensure the procedure code is appropriate for the revenue code used.
0399	Date Of Service Must Fall Between The Prior Authorization Grant Date And Expiration Date.
0408	Principal Diagnosis Code is not payable for the member.

Edit Number	Description
0409	No Reimbursement Rates on file for the Date(s) of Service.
0430	The lab panel is billed incorrectly. Refer to the CPT, HCPCS listing or the Provider Manual for laboratory billing instructions.
0441	5th Other Diagnosis (Institutional), 6th Diagnosis Code (Professional) is not a benefit.
0447	6th Other Diagnosis (Institutional), 7th Diagnosis Code (Professional) is not a benefit.
0451	Services with the Principal Diagnosis code are not a benefit.
0459	7th Other Diagnosis (Institutional), 8th Diagnosis Code (Professional) is not a benefit.
0461	1st Other Diagnosis (Institutional), 2nd Diagnosis Code (Professional/Dental) is not a benefit.
0471	2nd Other Diagnosis (Institutional), 3rd Diagnosis Code (Professional/Dental) is not a benefit.
0477	Services with the 8th Other Diagnosis code are not a benefit.
0481	3rd Other Diagnosis (Institutional), 4th Diagnosis Code (Professional/Dental) is not a benefit.
0491	4th Other Diagnosis (Institutional), 5th Diagnosis Code (Professional) is not a benefit.
0500	The supply procedure was billed and processed on a prior claim.
0503	Valid PA is not on file for this member and service.
0504	There is no PA on file for the procedure with the billed modifier. Check the appproved PA and verify the procedure and modifier
0511	This National Drug Code (NDC) is only payable as part of a compound drug.
0518	There is no valid PA on file for this item. The PA is denied, inactive, or rejected. Submit a PA for this service. When approved, enter the prior authorization number on the claim.
0522	The 3rd Other ICD Procedure is not a Covered Benefit.
0527	The 4th Other ICD Procedure is not a Covered Benefit.
0540	The service is not a benefit with an eye exam.
0550	The Principal ICD Procedure Code is not on file or invalid. Correct the procedure code.
0551	The Principal ICD Procedure is not a Covered Benefit.
0561	The 1st Other ICD Procedure is not a Covered Benefit.
0562	The 5th Other ICD Procedure is not a Covered Benefit.
0571	The 2nd Other ICD Procedure is not a Covered Benefit.
0578	Principal Diagnosis POA is missing or invalid.
585	Family Planning Indicator is invalid.
0596	The diagnosis indicator is missing or invalid. Enter/Correct the diagnosis indicator. Refer to the Provider Manual or Help Screens for valid indicators
0653	Insufficient Info On Unlisted Med Proc; Submit Claim Or Attachment With A Complete Description Of The Procedure As Described In History and Physical Exam Report, Med Progress, anesthesia or Op Report.
0665	Modifiers are required for reimbursement of these services.
0675	Claims for hysterectomies must be submitted on paper. Submit a paper claim with the required attachment.

Edit Number	Description
0678	Billing Provider Type and Specialty is not allowable for the Rendering Provider.
0718	Referring Provider ID is invalid. Referring Provider ID is not required for this service.
0719	Admission Date does not match Header From Date of Service.
0720	Billing Provider is not certified for the Date(s) of Service.
0770	The Revenue Code is not allowed for the Type of Bill indicated on the claim.
0801	One or more diagnosis codes are not applicable to the member's gender.
0807	Diagnosis code indicated is not valid as a primary diagnosis.
0810	A covered DRG cannot be assigned to the claim. The information on the claim is invalid or not specific enough to assign a DRG.
0925	This procedure is limited to once per day.
0931	Condition Code is missing/invalid or incorrect for the Procedure or Revenue Code submitted.
0937	This claim is being denied because it is an exact duplicate of claim submitted.
1000	Provider Submitted Reconsideration.
1006	The hospital classification of the billing provider does not fall within the hospital classification restriction.
1009	The maximum number of units allowed for this procedure code is 4 units per state fiscal year (July-June).
1010	This is a duplicate item that was previously processed and paid
1012	Billing provider is not eligible to bill for NHVP specific procedures
1013	New member visit already paid to this provider - Use appropriate established member code.
1015	CHP+ Fluoride Varnish only with Evaluation/Screening
1022	Billing provider must use either a GO or GP Procedure Code Modifier
1023	The maximum number of units allowed for this procedure code is two per calendarmonth. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1025	A valid enrolled ordering provider NPI is required.
1026	A valid enrolled Facility Provider NPI is required.
1027	Billing provider is not authorized to provide service from billing location.
1028	Rendering provider is not authorized to provide service from rendering location.
1030	The place of service code is invalid for procedure code. Correct the place of service code. Refer to the Provider Manual or Help Screens for valid place of service codes.
1035	A Surgical Assistant is not allowed for this procedure.
1042	Only one exam is allowed per day.
1044	Non-sterile gloves are limited to two boxes per calendar month. One unit of service is equal to one box. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1050	The diagnosis is invalid for the procedure. Correct the diagnosis/procedure code.

Edit Number	Description
1064	The maximum number of units allowed for this procedure code is two units per state fiscal year. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1065	The maximum number of units allowed for this procedure code is one unit per state fiscal year (July - June). You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1066	The maximum number of units allowed for this procedure code is five units per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1067	The maximum number of units allowed for this procedure code is sixteen units per Fiscal Year (July - June). You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1068	The maximum number of units allowed for this code is two units within three state fiscal years (fiscal year is July - June). You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1071	Acute HH and Long Term HH services cannot be billed the same day.
1072	Acute Home Health over daily limit.
1073	Long Term Home Health over daily limit.
1081	Billing Provider Not in the system list group.
1082	Calendar year benefit has been exceeded for purchase. Item(s) are limited to $750. 00 per calendar year, per member.
1083	Diapers are limited to 240 per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1084	Chux are limited to 150 per calendar month. You may resubmit the claim for up to the maximum allowed or submit a prior authorization request with justification of medical necessity.
1100	The admitting diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
1105	The 4th Other Diagnosis code (Institutional), 5th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
1106	The 5th Other Diagnosis code (Institutional), 6th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
1107	The 6th Other Diagnosis code (Institutional), 7th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
1108	The 7th Other Diagnosis code (Institutional), 8th Diagnosis Code (Professional) is invalid for member's sex Correct the diagnosis code/sex indicator.
1109	The 8th Other Diagnosis code (Institutional), 9th Diagnosis Code (Professional) is invalid for member's sex Correct the diagnosis code/sex indicator.
1112	A National Provider Identifier (NPI) is required for the Rendering Provider listed in the header.
1117	The National Drug Code (NDC) has an age restriction.
1118	The National Drug Code (NDC) has a quantity restriction.

Edit Number	Description
1120	One or more Diagnosis Codes has a gender restriction.
1122	Family Planning Funding 90%.
1123	Family Planning Funding Regular Match
1124	Family Planning Funding Error.
1127	The third modifier code is invalid for date of service. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a list
1152	The Sixth Diagnosis Code is invalid.
1156	Billed date is greater than batch date.
1177	Member Location is invalid.
1178	Service is not reimbursable for Date(s) of Service.
1183	Header From Date of Service is after the Header To Date of Service. The from date of service must be before the last date of service. Correct the from date o
1187	The Revenue Code is not payable for the Date(s) of Service.
1188	Discharge date/destination conflict. Correct discharge date or member status.
1195	The Procedure Code is not reimbursable for the Rendering Provider Type and/or Specialty.
1199	One or more of the NDCs submitted is not related to the procedure code billed.
1200	The pregnancy indicator is invalid for the member's age/sex. Verify the member's birth date/sex indicator.
1203	OUT OF STATE PROVIDER NOT CERTIFIED.
1204	Billing Provider is not certified for the Date(s) of Service.
1205	Out Of State Billing Provider Not Enrolled For Entire Detail DOS Span.
1210	The Billing Provider number or the NPI are missing or in conflict. Verify the Medicaid billing provider number, the National Provider Identification (NPI), th
1212	NDC HAS ENCOUNTER INDICATOR RESTRICTIONS
1213	The Procedure Code has Encounter Indicator restrictions.
1214	This Revenue Code has Encounter Indicator restrictions.
1215	The billed diagnosis code has encounter indicator restrictions.
1216	The billed ICD procedure code has encounter indicator restrictions.
1218	The billed procedure code has encounter indicator restrictions.
1219	The billed revenue code has encounter indicator restrictions.
1220	Modifier restriction on billed revenue code.
1221	Diagnosis Restriction on ICD Coverage Rule
1223	Billing Provider Type/Specialty not allowable for billed diagnosis.
1234	NDC NOT COVERED.
1240	The from date of service is missing or invalid. Enter/Correct the from date of service.
1252	The member is not eligible to receive BCCP services after age 65.
1255	DME rental beyond the initial 180 day period is not payable without prior authorization.
1261	Detail To Date of Service is invalid.
1273	Quantity Billed is invalid for the Revenue Code.

Edit Number	Description
1275	Quantity Billed is restricted for this procedure code.
1278	Place of Service code is invalid.
1281	ICD Procedure Code billed is not appropriate for the member's gender.
1284	Rendering Provider is not certified for the From Date of Service.
1290	Invalid Type of Bill for this Claim Type
1291	Valid Source of Admission is required.
1292	Type of bill is not allowable for the billed diagnosis.
1310	1 PC Dispensing Fee Allowed Per Date Of Service
1318	Fifth Other Surgical Code is invalid.
1319	First Other Surgical Code is invalid.
1320	Fourth Other Surgical Code is invalid.
1324	One or more Surgical Code(s) is invalid in positions six through 23.
1327	Principal Surgical Code is invalid.
1330	The total claim charge is invalid. Re-calculate and correct the total claim charge.
1331	No billing rule for revenue code.
1333	No billing rule for ICD procedure code.
1334	Header From Date of Service is invalid. Correct the From Date of Service.
1335	Header To Date of Service is invalid.
1336	Header To Date of Service is required.
1338	The net claim charge is missing or invalid. Recalculate and correct the net claim charge.
1340	Reimbursement rate is not on file for provider.
1345	Submitted referring provider NPI in the header is invalid.
1346	BILLING PROVIDER IS NOT CERTIFIED FOR THE DISPENSE DATE OF SERVICE.
1347	Billing provider number is not found or not valid for dates of service.
1348	PROVIDER NOT ALLOWED TO BILL THIS NDC.
1353	National Drug Code (NDC) is invalid.
1354	National Drug Code (NDC) is not on file.
1355	National Drug Code (NDC) is required.
1356	NDC INVALID FOR DISPENSE DATE OF SERVICE
1357	NDC NOT COVERED FOR CLAIM TYPE.
1362	DAW NOT ALLOWED FOR NDC.
1363	Medicare Coinsurance is greater than the annual limit. Verify and correct coinsurance amount.
1364	The National Drug Code (NDC) is not payable for the Provider Type and/or Specialty.
1365	NDC NOT COVERED FOR DATE OF SERVICE.
1367	NDC HAS DIAGNOSIS RESTRICTIONS.
1373	No procedure billing rule for lock in plan.
1376	Submitted referring provider NPI in the detail is invalid.

Edit Number	Description
1377	The Procedure Code has Diagnosis restrictions.
1378	The referring/supervising provider is not eligible on the date of service. Correct the referring/supervising provider number.
1379	The provider is not eligible for this category of service on the date of service
1380	ICD Procedure Code not covered for the date of service.
1381	No billing rule for procedure.
1387	Other Coverage Indicator is invalid.
1388	The Procedure Code is not reimbursable for the Rendering Provider Type and/or Specialty.
1390	The attending physician number is missing or invalid. Enter or verify the attending physician's 10-digit NPI number.
1393	Discharge Date is before the Admission Date. The discharge date cannot be before the admission date. Correct the discharge/admission date.
1395	Admission Date is on or after Date of Receipt of Claim. The Admission Date cannot be on or after the Date of Receipt on the Claim. Correct the Admission Date
1436	Acute and Long Term Home Health Revenue Code conflict - must be billed on separate claims.
1437	Second Other Surgical Code Date is invalid.
1445	The From Date of Service for the First Occurrence Span Code is invalid.
1446	The From Date of Service for the First Occurrence Span Code is required.
1447	The From Date of Service for the Second Occurrence Span Code is invalid.
1448	The From Date of Service for the Second Occurrence Span Code is required.
1449	The To Date of Service for the First Occurrence Span Code is invalid.
1450	The To Date of Service for the First Occurrence Span Code is required.
1451	The To Date of Service for the Second Occurrence Span Code is invalid.
1454	Procedure Code, Revenue Code, or Modifier is Invalid - Home Health
1457	Header To Date of Service is after the ICN date. The claim was received before the service was rendered. Services must be rendered before claims are submitted.
1460	There is no additional benefit for this service. Payment for this procedure was included in the payment for the surgery.
1462	The detail From Date of Service is after the detail To Date of Service. The from date of service must be before the last date of service. Correct the from date.
1464	Procedure Missing On Outpatient Claim - TOB 13x
1480	The total non-covered charges do not balance with the submitted charges. Re-calculate and enter the non-covered charges/submitted charges.
1483	This service is not a benefit of presumptive eligibility.
1503	A Rendering Provider number is required.
1504	Rendering Provider number is not found.
1507	A Rendering Provider is not required but was submitted on the claim.
1508	This claim was processed using the Medicaid provider ID number, because the system was unable to identify the provider by the National Provider Identifier (NPI) submitted on the

Edit Number	Description
	claim. Please submit future claims with the appropriate NPI, taxonomy and/or Zip +4 Code.
1512	The Procedure Code/Modifier combination is not payable for the Date of Service.
1514	The fourth modifier code is invalid for date of service. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a list
1515	The Primary Diagnosis Code is inappropriate for the Surgical Procedure Code.
1516	The Principal Diagnosis Code is inappropriate for the Revenue Code.
1517	The billed diagnos(es) are inappropriate for the procedure code.
1518	Diagnosis code is restricted by member age.
1519	The First Diagnosis Code is inappropriate for the Procedure Code.
1520	The Secondary Diagnosis Code is inappropriate for the Procedure Code.
1522	ICD Procedure Code is not allowed on the submitted claim type.
1524	Billed amount exceeds PA amount.
1526	Services billed exceed PA amount.
1530	No billing rule for diagnosis.
1532	Claim count of Present on Admission (POA) indicators does not match count of non-admitting and non-emergency diagnosis codes.
1541	The procedure code has Family Planning restrictions.
1542	The revenue code has Family Planning restrictions.
1544	Procedure is not billable with member's benefit plan.
1548	Type of bill is not allowable for the billed revenue code.
1550	Transplant services not payable without a transplant acquisition revenue code.
1552	This procedure is age restricted. Member's age does not fall within the approved age range.
1553	The procedure code and modifier combination is not covered for the member's benefit plan.
1554	The claim type and diagnosis code submitted are not payable.
1558	First detail diagnosis not allowable for the billed procedure.
1560	Procedure is not covered with this billing provider location.
1561	Revenue code is not covered with this billing provider location.
1562	Revenue code is not covered with this rendering provider location.
1563	Diagnos(es) not allowable for the billed revenue code.
1564	Diagnosis is not covered with this claim region
1565	ICD procedure is not covered with this claim type.
1566	ICD procedure is not covered with this claim region.
1567	Procedure on any detail restriction on procedure coverage rule.
1568	Revenue code is not covered with this principal header diagnosis.
1569	DRG is not reimbursable with this header diagnosis.
1570	DRG is not reimbursable for this claim type.

Edit Number	Description
1572	Procedure code is not reimbursable for this type of bill.
1573	Revenue code is not reimbursable for this type of bill.
1574	Procedure not covered for this claim region.
1575	Revenue code not covered for this claim region.
1577	Revenue code not covered for the member's benefit plan.
1592	Type of bill is not allowed for the billed procedure.
1598	The abortion procedure code(s) is not a benefit of the Colorado Medicaid Program. Submit a paper claim with appropriate documentation.
1599	Rendering Provider Type and/or Specialty is not allowable for the service billed.
1630	The principal ICD diagnosis code is missing. Enter the ICD diagnosis code.
1649	Revenue code requires submission of associated HCPCS code
1660	The date the plan of care was established is missing. Enter the date the plan of care was established.
1665	Unable To Process Your Adjustment Request. Member ID Not Present.
1666	Unable To Process Your Adjustment Request. Financial Payer Not Indicated.
1667	Unable To Process Your Adjustment Request. Provider ID Not Present.
1669	Unable To Process Your Adjustment Request. Original ICN Not Present.
1670	Unable To Process Your Adjustment Request. Member Not Found.
1671	Unable To Process Your Adjustment Request. Provider Not Found.
1672	Unable To Process Your Adjustment Request. Original Claim ICN Not Found.
1673	Unable To Process Your Adjustment Request. Claim Has Already Been Adjusted.
1674	Unable To Process Your Adjustment Request. A Different Adjustment Is Pending For This Claim.
1675	Unable To Process Your Adjustment Request. This Claim Is In Post Pay Billing For Third Party Liability Payment.
1676	Unable To Process Your Adjustment Request. Claim Can No Longer Be Adjusted. Contact Provider Services For Further Information.
1677	Unable To Process Your Adjustment Request. The Claim Type Of The Adjustment Does Not Match The Claim Type Of The Original Claim.
1678	Unable To Process Your Adjustment Request. Member ID Number On The Claim And On The Adjustment Request Do Not Match.
1679	Unable To Process Your Adjustment Request. Provider ID Number On The Claim And On The Adjustment Request Do Not Match.
1691	This service is not payable for the same date of service as another service included on the same claim, according to the National Correct Coding Initiative.
1692	Adjustment and original claim do not have the same financial payer.
1702	The ICD surgical procedure date is not within the header dates of service. The procedure must fall within these dates. Correct the surgical procedure/header d
1715	The serial number does not match the PA. The serial number on the claim must match the serial number on the PA. Verify/Correct the serial number.

Edit Number	Description
1720	The procedure code is missing. Enter the procedure code. Refer to the CPT or HCPCS listing for valid procedure codes.
1726	The Emergency Indicator Code is Invalid. Correct the emergency indicator.
1727	Emergency indicator restriction on billed procedure.
1728	Emergency Indicator Restriction on covered procedure.
1729	Admit Type Restriction on Covered Revenue Code.
1730	The Admission Date is after the From Date of Service. The Admission Date cannot be after the From Date. Correct the Admission/From Date
1731	Surgery Date is Before the Admission Date. The surgery date cannot be before the admission date. Correct the surgery/admission date.
1740	The number of details is not equal to the header detail count.
1786	The date of service date is out of timely filing. Complete the late bill override date information and attach documentation to prove timely filing continuity
1800	The tooth number is invalid/missing. Correct the tooth number.
1807	UNABLE TO PROCESS CALL PROVIDER SERVICES
1809	RENDERING PROVIDER IS NOT CERTIFIED.
1819	Verify billed amount and quantity billed. If correct, resubmit the claim.
1820	The tooth surface is missing. Enter the tooth surface.
1821	A covered APC/APG cannot be assigned to the claim. The information on the claim is invalid or not specific enough to assign an APC/APG.
1822	National Correct Coding Initiatives. This procedure has been approved for this date of service.
1830	The units of service are missing or invalid. Enter/Correct the units of service.
1840	The submitted charge is missing. Complete the submitted charge field.
1850	The admission date is missing or invalid. Enter/Correct the admission date.
1854	1st Cycle Mass Adjustment
1860	The admission hour is missing or invalid. Enter the admission hour.
1870	The admitting diagnosis is invalid. Correct the admitting diagnosis.
1891	The Principal ICD Procedure code or date is missing or invalid. Correct the code/date.
1900	1st External Cause of Injury Code is invalid. Correct the external cause of injury code.
1901	2nd External Cause of Injury Code is invalid. Correct the external cause of injury code.
1902	3rd External Cause of Injury Code is invalid. Correct the external cause of injury code.
1903	4th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1904	5th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1905	6th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1906	7th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1907	8th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1908	9th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1909	10th External Cause of Injury Code is invalid. Correct the external cause of injury code.

Edit Number	Description
1910	11th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1911	12th External Cause of Injury Code is invalid. Correct the external cause of injury code.
1920	The medical leave days/non-covered days are missing or invalid. Enter/Correct the number of medical leave days and/or the non-covered days.
1930	The covered/non-covered days are missing or invalid. Enter/Correct the number of covered/non-covered days.
1951	Supervising NPI is inactive.
1952	No match found for Supervising NPI.
1953	Invalid Internal Supervising Provider Specified - Header.
1954	NPI is required for Supervising Provider
1955	Invalid internal supervising prov specified - Detail.
1956	Supervising Provider is not Medicaid certified
1959	Procedure not allowed to be billed with Assistant Surgeon. Please resubmit with medical necessity information.
1961	Billing NPI and Medicaid ID does not match.
1963	Unique Provider Service Location could not be found for Attending NPI
1964	Other 1 and Medicaid ID does not match.
1965	No match found for Other 2 NPI
1966	Unique Provider Service Location could not be found for Other 2 NPI
1967	Other 2 NPI is inactive.
1968	Other 2 NPI is required.
1969	Other 2 and Medicaid ID does not match.
1970	Unique Provider Service Location could not be found for Other 1 NPI
1971	A supervising NPI provider is required for the billed procedure. Such claims may be subject to review. .
1972	Processed Per Policy Supervising NPI and Medicaid ID does not match.
1973	Attending NPI Inactive.
1974	Attending NPI and Medicaid ID does not match
1975	No Match Found for Other 1 NPI
1976	Rendering NPI Inactive
1977	Unique Provider Service Location could not be found for Other 1 NPI - Detail
1978	Unique Provider Service Location could not be found for Rendering NPI
1979	Other 1 NPI Inactive
1980	Other 1 NPI Required
1981	The Principal ICD Procedure code or date is missing or invalid. Correct the code/date.
1982	The 1st Other ICD Procedure code or date is missing or invalid. Correct the code/date.
1983	2nd Other ICD Procedure Code/Date Missing or Invalid
1984	3rd Other ICD Procedure Code/Date Missing or Invalid
1985	4th Other ICD Procedure Code/Date Missing or Invalid

Edit Number	Description
1986	5th Other ICD Procedure Code/Date Missing or Invalid
1987	PRTF line item not paid on discharge date
1988	Unique Provider Service Location was not found for Other 2 NPI - Detail
1989	The PRTF claim is missing key data - Revenue code 911 or type of bill 89X
1990	Acute HH and Long Term HH services cannot be billed the same day.
1991	PETI amount is greater than member pay amount
1992	PETI greater than $0. 00 requires occurrence span code 76
1993	Processed Per Policy PETI must be billed with accommodation revenue code
1994	Unique Provider Service Location was not found for Referring Provider - Header. Please resubmit the claim using taxonomy and zip+4.
1995	Unique Provider Service Location was not found for Referring Provider - Detail. Please resubmit the claim using taxonomy and zip+4.
2000	The type of admission is missing or invalid. Enter/Correct the type of admission. Refer to the UB04 Provider Manual or Help Screens for valid codes.
2001	Benefit is limited to one per day.
2002	Individual/Family Therapy is limited to 4 units per day.
2003	Group Therapy limited to 2 per day.
2004	Targeted Case Management (TCM) is limited to 4 units per day.
2008	Benefit is limited to 36 units per State Fiscal Year.
2009	Benefit is limited to 21 units per State Fiscal Year.
2018	This procedure code is limited to 24 per date of service for School Health Service.
2021	A National Correct Coding Initiative (NCCI) procedure to procedure edit that is comprised of three scenarios: Comprehensive/Component (Column I/Column II) edits, Mutually Exclusive edits, and Action on History. These three scenarios are edits that compare procedure code pairs to identify coding logic conflicts.
2022	A National Correct Coding Initiative (NCCI) Medically Unlikely Edit (MUE) that sets when the units of service are billed in excess of established standards for services that a member would receive on a single date of service for a given CPCS/CPT code.
2122	Individual/Family Therapy is Limited to 8 units per day.
2123	Group Therapy limited to 3 per day.
2124	Benefit is limited to 108 units per State Fiscal Year.
2125	Screening is limited to 52 units per State Fiscal Year.
2126	Safety is limited to 15 units per State Fiscal Year.
2220	Policy not currently enforced - Delta
2222	Policy not currently enforced.
2280	The Medicare paid date is missing or invalid. Enter the Medicare paid date from the Medicare explanation of benefits and retain the explanation of benefits.
2300	NF and LTSS overlap
2303	Hospital Readmission too close to last discharge
2305	Occupational therapy services limited to a maximum of 24 units per 366 days.

Edit Number	Description
2306	Occupational therapy services limited to a maximum of 5 units per date of service.
2307	Physical Therapy services are limited to a maximum of 24 units per 366 days.
2308	Physical therapy services limited to maximum of 5 units per date of service.
2309	Benefit is limited to 35 units per State Fiscal Year.
2314	Benefit is limited to 3 units per day.
2315	Benefit is limited to 3 units per State Fiscal Year
2316	Individual/Family Therapy is limited to 100 units per State Fiscal Year.
2317	Benefit is limited to 4 units per 12 months.
2326	Home Health Telehealth limited to 1 setup/lifetime.
2327	Benefit is limited to 45 units per State Fiscal Year.
2328	Screening is limited to 3 units per State Fiscal Year.
2329	Benefit is limited to 2 units per State Fiscal Year.
2332	Benefit is limited to 16 units per day.
2333	Benefit is limited to 1 unit per day.
2334	Benefit is limited to 24 units per day.
2335	Exceeds 60-day limit for Acute Home Health.
2341	Limit 1 every 3 State Fiscal Years
2350	1 per calendar month
2351	31 per calendar month
2352	35 per calendar month
2353	50 per calendar month
2354	60 per calendar month
2355	62 per calendar month
2356	100 per calendar month
2357	120 per calendar month
2358	155 per calendar month
2359	180 per calendar month
2360	3 per calendar month
2361	4 per SFY
2362	6 per calendar month
2363	6 per SFY
2364	12 per SFY
2365	15 per calendar month
2366	20 per calendar month
2367	30 per calendar month
2368	DME Rent to Own - Purchase Price limit
2369	Benefit limited to a maximum of total days in a month.
2371	Benefit is limited to 2 units per calendar year.

Edit Number	Description
2374	NHVP benefit limited to 15 units per calendar month.
2375	NHVP benefit limited to a maximum of 495 units per 33 calendar months.
2376	NHVP benefit limited to a maximum of 375 units per 25 calendar months.
2377	Initial EPSDT Screening Is Limited to one per 3 years.
2378	Exceeds Limit 1 Visit per Fiscal Year
2381	Benefit is limited to $400. 00 per calendar year.
2382	Assistive Technology, Vehicle Modification, Home Accessibility Modification HCBS-SLS and HCBS-CES waiver benefit limit has been reached.
2383	Non Medical Transportation HCBS-SLS waiver benefit limited to 4 units per week.
2384	Residential Habilitation Services and Support DIDD benefit limited to 1 unit per day.
2385	Respite Individual Day HCBS-SLS and HCBS-CES waiver benefit limited to 40 units per day.
2386	Office visits limited to 1 per day.
2387	Nursing Facility visits limited to1 per day.
2391	BHO Per Diem benefit is limited to 1 per day.
2393	Prefabricated caps limited to 5 units per date of service.
2394	School Health Services limited to 6 units per day.
2396	School Health Services limited to 40 units per day.
2397	Targeted Casa Mana (TCM) is limited to 240 units per State Fiscal Year.
2398	Benefit is limited to 1 unit per 12 months.
2399	Benefit is limited to 1 unit per 24 months.
2400	Benefit is limited to 1 unit per 36 months.
2401	Benefit is limited to 1 unit per 60 months.
2402	Benefit is limited to 1 per lifetime per tooth.
2403	Benefit is limited to 2 units per 12 months.
2404	Benefit is limited to 2 units per 60 months.
2405	Benefit is limited to 3 units per 60 months
2406	Denture benefit is limited to 1 unit per 60 months.
2407	CHP+ Fluoride Varnish
2409	CHP+ PT OT ST Visit Limitations
2412	Multiple Surgeries Billed. Benefit limited to 1 unit per day.
2415	Long Term HH and Group Res Svc DIDD
2416	Respite Individual Limit SLS and CES Waivers
2418	Dental service cannot be billed with CPT history.
2419	The CPT code cannot be billed with dental service history.
2427	Bill Telehealth with Acute Home Health
2428	Bill Telehealth with Long Term Care HH Service
2430	The TCN to credit is missing or invalid. Enter/Correct the TCN of the original claim to be credited.

Edit Number	Description
2449	Invalid ICD diagnosis qualifier
2450	The discharge date is before the through date. Correct the discharge/through date.
2451	The discharge hour is invalid. Please correct the discharge hour.
2452	The discharge hour is missing. Please correct the discharge hour.
2500	The members State ID number is not on file. Enter the member State ID number as it appears on the eligibility inquiry.
2520	The dates of service overlap eligibility span. Member is not eligible on each date of the span billed on the claim. Refer to the eligibility dates on the eligibility inquiry and split the claim.
2530	Possible member death. Check the eligibility inquiry.
2580	The services must be billed to the HMO/PHP listed on the eligibility inquiry.
2590	The member has Medicare. Charges must billed to Medicare before billing Medicaid. Complete the Medicare payment information fields on the claim and retain a copy of the explanation of benefits.
2640	Claim indicates TPL or TPL payment, no resource on file.
2710	The member is ineligible on the date of service. Check the eligibility inquiry and verify the date of service.
2730	The member is in the Locked-in program. The Lock-in provider number must be either the billing, rendering, referring or supervising provider number on the claim.
2740	Claim indicates member death or discharge from NF
2790	The claim date of service is over 4 years old. Submit the claim on paper to the fiscal agent's Medicaid Exceptions Unit with documentation supporting the processing request.
2860	The billed procedure code is not on file for this provider. The claim cannot be processed. Verify the procedure code.
2900	Other Physician 1 must contain the Nursing Facility Provider number for payment of Hospice Room and Board services.
2941	APR-DRG HAC - The diagnosis cannot be used as a principal diagnosis.
2945	APR-DRG HAC - The discharge status is invalid. Correct the discharge status. Refer to the UB04 Provider Manual or Help Screens for valid codes.
2948	APR-DRG HAC - Invalid age in years or admission age in days
2949	APR-DRG HAC - Record does not meet criteria for any DRG
2951	APR-DRG HAC - Invalid discharge age in days.
2952	APR-DRG HAC - The principal diagnosis is invalid.
2953	APR-DRG - Invalid admitting diagnosis code.
2954	APR-DRG - Invalid principal diagnosis code.
2955	APR-DRG - Principal diagnosis gender conflict.
2956	APR-DRG - Principal diagnosis age conflict.
2957	APR-DRG - E-code used as a principal diagnosis.
2958	APR-DRG - Non-specific principal diagnosis.
2959	APR-DRG - Manifestation used as principal diagnosis.

Edit Number	Description
2960	Claim processed with closest eligibility span.
2961	APR-DRG - Unacceptable principal diagnosis
2962	APR-DRG - A secondary diagnosis is required.
2963	APR-DRG - Secondary diagnosis code is invalid
2964	APR-DRG - Secondary diagnosis gender conflict.
2965	APR-DRG - Secondary diagnosis is a duplicate of the principal diagnosis.
2966	APR-DRG - Secondary diagnosis age conflict.
2967	APR-DRG - Invalid ICD procedure code
2968	APR-DRG - ICD procedure gender conflict.
2969	APR-DRG - ICD procedure is a bilateral procedure.
2970	APR-DRG - ICD procedure is inconsistent with length of stay.
2971	APR-DRG HAC - Invalid birth weight.
2972	APR-DRG HAC - Gestational age/birth weight conflict.
2981	EAPGS - Age/Sex Conflict with Diagnosis/Procedure Code.
2985	EAPGS - Ensure if an additional modifier is necessary in order to differentiate services. Such claims may be subject to review.
2986	EAPGS - Ensure whether a modifier is necessary to differentiate same-day services. Such claims may be subject to review.
2990	This claim was processed by the Enhanced Ambulatory Patient Grouping System (EAPGS).
2991	EAPGS - Invalid or Missing Information (header)
2992	EAPGS - Invalid or Missing Information (detail)
3011	EAPGS - E-diagnosis codes are not allowed as a primary diagnosis.
3012	EAPGS - This service cannot be performed in an outpatient hospital setting
3014	EAPGS - Diagnosis is either invalid for date(s) of service or requires greater specificity.
3015	EAPGS-Reason for visit diagnosis code required for revenue code indicated.
3020	Billing Provider Type and/or Specialty is not allowable for the revenue code billed.
3029	Claim filing value is invalid.
3030	Coverage limited to federal legend drugs or over-the-counter drugs.
3033	Inpatient Units/Covered/Non-Covered Days Conflict
3040	The rendering provider is not enrolled on the date(s) of service
3051	Rendering provider under review - suspend all claims.
3052	Attending provider under review.
3070	Paraprofessionals require a supervising/billing provider. Complete the supervising/billing provider number field.
3090	Billing provider under review - suspend all claims
3110	The rendering provider is not a group member. Verify the rendering provider number/group number.
3120	The billing provider is not eligible on date(s) of service.

Edit Number	Description
3130	The Principal Diagnosis code (Institutional), 1st Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.
3142	The 1st Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
3143	The 2nd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
3144	The 3rd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
3145	The 4th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
3146	The 5th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
3170	The first modifier code is invalid for date of service. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a listing.
3171	The second modifier code is invalid for date of service. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS for a list
3180	The procedure code is invalid. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.
3181	The procedure code is invalid for date of service. Correct the procedure code. Refer to the CPT or the HCPCS listing for valid procedure codes.
3230	The admitting diagnosis code is invalid for member's age. Correct the diagnosis code/member's birth date.
3231	The Principal Diagnosis code (Institutional), 1st Diagnosis code (Professional/Dental) is invalid for member's age. Correct the diagnosis code/member's birth
3232	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis code (Professional/Dental) is invalid for member's age. Correct the diagnosis code/member's birth
3233	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis code (Professional/Dental) is invalid for member's age. Correct the diagnosis code/member's birth
3234	The 3rd Other Diagnosis code (Institutional), 4th Diagnosis code (Professional/Dental) is invalid for member's age. Correct the diagnosis code/member's birth
3235	The 4th Other Diagnosis code (Institutional), 5th Diagnosis code (Professional) is invalid for member's age. Correct the diagnosis code/member's birth date.
3236	The 5th Other Diagnosis (Institutional) is invalid for member's age. Correct the diagnosis code/member's birth date.
3237	The 6th Other Diagnosis (Institutional) 7th Diagnosis Code (Professional) is invalid for member's age. Correct the diagnosis code/member's birth date.
3238	The 7th Other Diagnosis (Institutional), 8th Diagnosis Code (Professional) is invalid for member's age. Correct the diagnosis code/member's birth date.
3239	The 8th Other Diagnosis (Institutional), 9th Diagnosis code (Professional) is invalid for member's age. Correct the diagnosis code/member's birth date.
3241	The Principal Diagnosis code (Institutional), 1st Diagnosis Code (Professional/Dental) is invalid for member's sex. Correct the diagnosis code/sex indicator.
3242	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis Code (Professional/Dental) is invalid for member's sex. Correct the diagnosis code/sex indicator.
3243	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional/Dental) is invalid for member's sex. Correct the diagnosis code/sex indicator.

Edit Number	Description
3244	The 3rd Other Diagnosis code (Institutional), 4th Diagnosis Code (Professional/Dental) is invalid for member's sex. Correct the diagnosis code/sex indicator.
3261	The procedure code currently is not a benefit for date of service billed. Refer to the CPT or the HCPCS listing for valid procedure codes.
3280	The member's age is invalid for this procedure code. Verify the member's birth date/procedure code.
3290	The member's gender is invalid for this procedure code. Verify the gender/procedure code.
3291	The Principal Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.
3292	The 1st Other Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present
3294	The 3rd Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3296	The 4th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3298	The 5th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3300	The 6th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3302	The7th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3304	The 8th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3306	The 9th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3312	The 10th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3318	The 11th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3323	Denied. Take Home Drugs Not Billable On UB92 Claim Form. Rebill On Pharmacy Claim Form.
3324	The 12th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3330	The 13th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3336	The 14th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3342	The 15th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3348	The 16th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.

Edit Number	Description
3354	The 17th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3360	The 18th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3366	The 19th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3372	The 20th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3378	The 21st Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3384	The 22nd Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3390	The 23rd Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3396	The 24th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3402	The 25th Other Diagnosis code (Institutional), 3rd Diagnosis Code (Professional) OPPC). CMS does not allow reimbursement when an OPPC is present.
3408	The Admitting Diagnosis is a CMS-defined Other Provider Preventable Condition (OPPC). CMS does not allow reimbursement when an OPPC is present.
3409	1st Other Diagnosis POA is missing or invalid.
3410	2nd Other Diagnosis POA is missing or invalid.
3411	3rd Other Diagnosis POA is missing or invalid.
3412	4th Other Diagnosis POA is missing or invalid.
3413	5th Other Diagnosis POA is missing or invalid.
3414	6th Other Diagnosis POA is missing or invalid.
3415	7th Other Diagnosis POA is missing or invalid.
3416	8th Other Diagnosis POA is missing or invalid.
3417	9th Other Diagnosis POA is missing or invalid.
3418	10th Other Diagnosis POA is missing or invalid.
3419	11th Other Diagnosis POA is missing or invalid.
3420	12th Other Diagnosis POA is missing or invalid.
3421	13th Other Diagnosis POA is missing or invalid.
3422	14th Other Diagnosis POA is missing or invalid.
3423	15th Other Diagnosis POA is missing or invalid.
3424	16th Other Diagnosis POA is missing or invalid.
3425	17th Other Diagnosis POA is missing or invalid.
3426	18th Other Diagnosis POA is missing or invalid.
3427	19th Other Diagnosis POA is missing or invalid.
3428	20th Other Diagnosis POA is missing or invalid.

Edit Number	Description
3429	21st Other Diagnosis POA is missing or invalid.
3430	22nd Other Diagnosis POA is missing or invalid.
3431	23rd Other Diagnosis POA is missing or invalid.
3432	24th Other Diagnosis POA is missing or invalid.
3449	The Accept Assignment indicator is Missing/Invalid or the Claim Form is invalid
3461	The referring provider number is not on file. Verify the 8-digit Medicaid provider number of the other provider.
3530	There is no rate on file for the date of service. Charges cannot be processed.
3581	System Error - Parameter Not Found For DOS
3582	Missing Parameter Number for RVS Pricing.
3620	The Medicare deductible on the claim is greater than annual amount. The deductible amount must match the amount on the Medicare explanation of benefits. Correct the deductible amount.
3660	The service is not within the scope of the billing provider's CLIA certification. Please update the MMIS provider records with the correct CLIA number for the
3670	The primary care physician provider number is invalid/missing. Correct/Enter the primary care physician provider number.
3690	The PCP provider number is invalid for the date of service. Check the eligibility inquiry for the PCP. Contact the PCP for the provider number and enter it
3720	The 1st Other Diagnosis code (Institutional), 2nd Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.
3730	The 2nd Other Diagnosis code (Institutional), 3rd Diagnosis code (Professional/Dental) is invalid. Correct the diagnosis code.
3740	The 3rd Other Diagnosis code (Institutional), 4th Diagnosis Code (Professional/Dental) is invalid. Correct the diagnosis code.
3751	The revenue code is missing. Enter the revenue code. Refer to the current revenue code table for valid revenue codes.
3752	The revenue code is not on file. Refer to the current revenue code table for valid codes.
3756	The revenue code is not valid for this date of service. Refer to the current revenue code table for valid codes.
3780	The supervising provider number is not on file. Verify the supervising provider number. .
3891	The assigned DRG is not on file.
3930	The 4th Other Diagnosis code (Institutional), 5th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
3950	The dates of service span the end of the year. Claim must be split by year.
3960	Modifier Restriction on Reimbursement Revenue Rule
4000	The member has other insurance. Bill the charges to the other insurance before billing Medicaid. Complete the other insurance payment information fields on the claim and retain a copy of the explanation of benefits.
4040	Third Party Liability (TPL) other insurance denied.

Edit Number	Description
4060	The provider's signature is missing. Complete signature field indicator, or include signature certification page for the dental or UB04 forms.
4070	The last date of service is missing or invalid. Enter/Correct the last date of service.
4081	1st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4082	2nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4083	3rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4084	4th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4085	5th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4086	6th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4087	7th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4088	8th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4091	The 1st value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4092	The 2nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4093	The 3rd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4094	The 4th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4095	The 5th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4096	The 6th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4097	The 7th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4098	The 8th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4099	The 9th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4100	The type of bill is missing or invalid. Enter/Correct the type of bill. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4101	The 10th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.

Edit Number	Description
4102	The 11th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4103	The 12th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4104	The 13th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4105	The 14th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4106	The 15th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4107	The 16th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4108	The 17th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4109	The 18th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4110	The source of admission is missing or invalid. Enter/correct the source of admission. Refer to the UB04 Provider Manual or Help Screens for valid source of
4111	The 19th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4112	The 20th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4113	The 21st value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4114	The 22nd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4115	The 23rd value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4116	The 24th value code or amount is missing. Enter the value code/amount. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4122	The 2nd condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4123	The 3rd condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4124	The 4th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4125	The 5th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4126	The 6th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.
4127	The 7th condition code is invalid. Correct the condition code. Refer to the UB04 Provider Manual or Help Screens for valid codes.

Edit Number	Description
4211	Modifier is invalid for procedure code. Read the procedure description. Refer to the Provider Manual, Help Screens, CPT or HCPCS listing for valid modifiers.
4223	Medical Review Restriction on Procedure Code Coverage Rule.
4253	Medical Review Restriction on Revenue Code Coverage Rule.
4254	Age Restriction on Revenue Code Coverage Rule.
4270	The programmatic leave days are exceeded. Bill excess programmatic leave days as medical leave days.
4350	The dates of service span the end of the month. Claim must be split by month.
4360	The detail date of service is missing or invalid. Enter/Correct the detail date of service. The detail dates of service must fall within the header dates of
4470	Interim DRG bills cannot be processed.
4480	Cutback days for DRG based on Member eligibility.
4510	The charges are not a benefit. The member has Medicare QMB only.
4540	The member has QMB benefits only. Medicaid benefits are paid for crossover claims only.
4600	The coinsurance/deductible is billed incorrectly. The deductible/coinsurance on the claim must match the deductible/coinsurance on the Medicare explanation of benefits or the other insurance explanation of benefits.
4610	The member aid category spans Old Age Pension. Check the eligibility inquiry and split the claim.
4620	The service is not a benefit for the recipient aid category (OAP).
4700	The revenue code must be a radiology code. Refer to the current revenue code table for valid codes.
4710	The revenue code/HCPCS code combination is invalid. Refer to the UB04 Provider Manual for instructions.
4758	Billing Provider Type/Specialty Restriction on Procedure Coverage Rule.
4759	Provider Contract Restriction on Procedure Coverage Rule.
4760	The service is a Medicare benefit only.
4761	Contract Restriction on Revenue Code Coverage Rule.
4780	Revenue code restriction on billed procedure.
4840	Services for undocumented aliens are limited to emergencies. The billed service is not a benefit.
4900	The line item units of service exceed the total number of days. The line item units cannot be greater than the total number of days. Re-calculate and enter the units of service/total number of days.
4901	Billing Provider Geographic Location Restriction on Revenue Reimbursement Rule.
4902	Member Geographic Location Restriction on Revenue Reimbursement Rule.
4903	Procedure is not covered. (Does not match Procedure Group on Procedure Coverage Rule)
4920	The hospice units of service are invalid. Recalculate and enter the hospice units of service.
4930	The total units of service cannot exceed the total number of days. Re-calculate and enter the total units of service/total number of days.

Edit Number	Description
5030	The procedure code is invalid for the claim type. Correct the procedure code or bill the procedure code on the correct claim type.
5110	The prior authorization does not match the services billed on your claim. Please correct services or submit a new prior authorization for the services billed
5260	The 5th Other Diagnosis code (Institutional), 6th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
5270	The 6th Other Diagnosis code (Institutional), 7th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
5280	The 7th Other Diagnosis code (Institutional), 8th Diagnosis Code (Professional) is invalid. Correct the diagnosis code
5290	The 8th Other Diagnosis code (Institutional), 9th Diagnosis Code (Professional) is invalid. Correct the diagnosis.
5300	The Admitting Diagnosis Code is invalid. Correct the admitting diagnosis code.
5310	The detail lines are missing or the maximum number of lines has been exceeded. Enter the detail lines. If the maximum number is exceeded, split the claim.
5320	PREVIOUS REHAB CLAIM <= 30 DAYS
5340	The principal diagnosis is invalid for DRG claims. Correct the principal diagnosis.
5820	The number of tooth surfaces is missing or invalid for the procedure. Correct the number of tooth surfaces/procedure.
5970	The abortion ICD surgical procedure(s) is not a benefit of the Colorado Medicaid Program. Submit a paper claim with appropriate documentation.
5990	The abortion diagnosis code(s) is not a benefit of the Colorado Medicaid Program. Submit a paper claim with appropriate documentation.
6700	Sterilization form missing or invalid. Submit a paper claim with the completed Med-178 attached.
6990	The claim must be submitted electronically.
7200	9th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7202	10th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7204	11th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7206	12th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7208	13th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7210	14th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7212	15th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7214	16th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.

Edit Number	Description
7216	17th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7218	18th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7220	19th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7222	20th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7224	21st Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7226	22nd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7228	23rd Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7230	24th Occurrence Code/Date invalid or missing. Correct Code/Date. Refer to the UB04 Provider Manual or Help Screens for valid codes.
7232	6th Other ICD Procedure Code/Date Missing or Invalid
7233	The 6th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7234	The 6th Other ICD Procedure is not a Covered Benefit.
7235	7th Other ICD Procedure Code/Date Missing or Invalid
7236	The 7th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7237	The 7th Other ICD Procedure is not a Covered Benefit.
7238	8th Other ICD Procedure Code/Date Missing or Invalid
7239	The 8th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7240	The 8th Other ICD Procedure is not a Covered Benefit.
7241	9th Other ICD Procedure Code/Date Missing or Invalid
7242	The 9th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7243	The 9th Other ICD Procedure is not a Covered Benefit.
7244	10th Other ICD Procedure Code/Date Missing or Invalid
7245	The 10th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7246	The 10th Other ICD Procedure is not a Covered Benefit.
7247	11th Other ICD Procedure Code/Date Missing or Invalid
7248	The 11th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7249	The 11th Other ICD Procedure is not a Covered Benefit.
7250	12th Other ICD Procedure Code/Date Missing or Invalid
7251	The 12th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7252	The 12th Other ICD Procedure is not a Covered Benefit.
7253	13th Other ICD Procedure Code/Date Missing or Invalid
7254	The 13th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7255	The 13th Other ICD Procedure is not a Covered Benefit.

Edit Number	Description
7256	14th Other ICD Procedure Code/Date Missing or Invalid
7257	The 14th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7258	The 14th Other ICD Procedure is not a Covered Benefit.
7259	15th Other ICD Procedure Code/Date Missing or Invalid
7260	The 15th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7261	The 15th Other ICD Procedure is not a Covered Benefit.
7262	16th Other ICD Procedure Code/Date Missing or Invalid
7263	The 16th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7264	The 16th Other ICD Procedure is not a Covered Benefit.
7265	17th Other ICD Procedure Code/Date Missing or Invalid
7266	The 17th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7267	The 17th Other ICD Procedure is not a Covered Benefit.
7268	18th Other ICD Procedure Code/Date Missing or Invalid
7269	The 18th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7270	The 18th Other ICD Procedure is not a Covered Benefit.
7271	19th Other ICD Procedure Code/Date Missing or Invalid
7272	The 19th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7273	The 19th Other ICD Procedure is not a Covered Benefit.
7274	20th Other ICD Procedure Code/Date Missing or Invalid
7275	The 20th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7276	The 20th Other ICD Procedure is not a Covered Benefit.
7277	21st Other ICD Procedure Code/Date Missing or Invalid
7278	The 21st Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7279	The 21st Other ICD Procedure is not a Covered Benefit.
7280	22nd Other ICD Procedure Code/Date Missing or Invalid
7281	The 22nd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7282	The 22nd Other ICD Procedure is not a Covered Benefit.
7283	23rd Other ICD Procedure Code/Date Missing or Invalid
7284	The 23rd Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7285	The 23rd Other ICD Procedure is not a Covered Benefit.
7286	24th Other ICD Procedure Code/Date Missing or Invalid
7287	The 24th Other ICD Procedure Code is not on file or invalid. Correct the procedure code.
7288	The 24th Other ICD Procedure is not a Covered Benefit.
7307	The 9th Other Diagnosis Code (Institutional), 10th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
7308	Services with the 9th Other Diagnosis code are not a benefit.
7310	The 9th Other Diagnosis code (Institutional), 10th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.

Edit Number	Description
7313	The 10th Other Diagnosis Code (Institutional), 11th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
7314	Services with the 10th Other Diagnosis code are not a benefit.
7315	The 10th Other Diagnosis (Institutional), 11th Diagnosis Code (Professional) is invalid for member's age. Correct the diagnosis code/member's birth date.
7316	The 10th Other Diagnosis code (Institutional), 11th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
7319	The 11th Other Diagnosis Code (Institutional), 12th Diagnosis Code (Professional) is invalid. Correct the diagnosis code.
7320	Services with the 11th Other Diagnosis code are not a benefit.
7321	The 11th Other Diagnosis (Institutional), 12th Diagnosis Code (Professional) is invalid for member's age. Correct the diagnosis code/member's birth date.
7322	The 11th Other Diagnosis code (Institutional), 12th Diagnosis Code (Professional) is invalid for member's sex. Correct the diagnosis code/sex indicator.
7325	The 12th Other Diagnosis Code (Institutional) is invalid. Correct the diagnosis code.
7326	Services with the 12th Other Diagnosis code are not a benefit.
7327	The 12th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7328	The 12th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7331	The 13th Other Diagnosis Code (Institutional) is invalid. Correct the diagnosis code.
7332	Services with the 13th Other Diagnosis code are not a benefit.
7333	The 13th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7334	The 13th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7337	The 14th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7338	Services with the 14th Other Diagnosis code are not a benefit.
7339	The 14th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7340	The 14th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7343	The 15th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7344	Services with the 15th Other Diagnosis code are not a benefit.
7345	The 15th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7346	The 15th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7349	The 16th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7350	Services with the 16th Other Diagnosis code are not a benefit.

Edit Number	Description
7351	The 16th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7352	The 16th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7355	The 17th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7356	Services with the 17th Other Diagnosis code are not a benefit.
7357	The 17th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7358	The 17th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7361	The 18th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7362	Services with the 18th Other Diagnosis code are not a benefit.
7363	The 18th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7364	The 18th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7367	The 19th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7368	Services with the 19th Other Diagnosis code are not a benefit.
7369	The 19th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7370	The 19th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7373	The 20th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7374	Services with the 20th Other Diagnosis code are not a benefit.
7375	The 20th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7376	The 20th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7379	The 21st Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7380	Services with the 21st Other Diagnosis code are not a benefit.
7381	The 21st Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7382	The 21st Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7385	The 22nd Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7386	Services with the 22nd Other Diagnosis code are not a benefit.
7387	The 22nd Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7388	The 22nd Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7391	The 23rd Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code

Edit Number	Description
7392	Services with the 23rd Other Diagnosis code are not a benefit.
7393	The 23rd Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7394	The 23rd Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7397	The 24th Other Diagnosis Code (Institutional) is Invalid. Correct the diagnosis code
7398	Services with the 24th Other Diagnosis code are not a benefit.
7399	The 24th Other Diagnosis is invalid for member's age. Correct the diagnosis code/member's birth date.
7400	The 24th Other Diagnosis code is invalid for member's sex. Correct the diagnosis code/sex indicator.
7404	Services with the Admitting Diagnosis code are not a benefit.
7433	1st Member Reason for Visit is Invalid.
7434	2nd Member Reason for Visit is Invalid.
7435	3rd Member Reason for Visit is Invalid.
7436	APR-DRG No Price on File
7437	APR-DRG Not Covered.
7438	Assigned APR-DRG Code Requires Manual Review - header.
7439	Assigned APR-DRG Code Age Conflict.
7441	Assigned APR-DRG Code Requires Manual Review - detail.
7442	Transfer from one Distinct Unit to another of same hospital must be billed as one continuous stay.
7443	Service must be billed as Outpatient.
7444	This abortion service is not a covered benefit.
7445	PreAdmission Testing should be billed as Outpatient.
7448	APR-DRG HAC - Gender conflict
8000	Resolution review.
8001	Unable To Process This Request Due To Illegible Information.
8002	Unable to Process This Request Due to either Missing, Invalid, or Mismatched National Provider Identifier Number (NPI)/Provider Name/Medicaid Provider ID
8183	Member Liability Adjustments
8186	Mass Adjustment - Provider Rate Process.
8188	MASS OR SINGLE VOID TRANSACTIONS
8193	This claim has been adjusted due to a change in the member's enrollment.
8194	This claim has been adjusted because a service on this claim is not payable in conjunction with a separate paid service on the same date of service due to National Correct Coding Initiative.
8200	TPL Private Health Insurance - Carrier
8201	TPL Private Health Insurance - Provider
8202	TPL Private Health Insurance - Member

Edit Number	Description
8203	Auto Liability - Carrier
8204	Auto Liability - Provider
8205	Auto Liability - Member
8206	Non-auto Liability - Carrier
8207	Non-auto Liability - Provider
8208	Non-auto Liability - Member
8209	Worker's Comp - Carrier
8210	Worker's Comp - Provider
8211	Worker's Comp - Member
8212	Probate's Estate
8213	Income Pension Trust Recoveries
8214	Victim's Restitution
8215	Absent Parents
8216	TPL Error
8217	Due To Miscellaneous Or Unspecified Reason
8222	Adjustment/Resubmission was initiated by Provider
8225	Capitation - Death Of Member
8226	Capitation - Member Incarcerated
8227	Capitation - EPSDT Claim
8228	Capitation - Member Enrolled In Error
8229	Capitation - Family Planning
8230	Capitation - Incorrect Rate Category
8231	Capitation - Demographic Change
8232	Capitation - Other
8233	Adjustment/Resubmission was initiated by DHS
8234	Adjustment/Resubmission was initiated by Fiscal Agent.
8240	Adjustment Generated Due To SUR Review
8241	Adjustment Generated Due To Change In Member Liability
8242	Adjustment Generated Due To Rate Change
8244	Payout Processed Due To Disproportionate Share
8245	Point Of Sale
8246	Point Of Sale Reversal
8410	Financial Check Void/Stop Pay
8600	01-M/I BIN
8601	02-M/I VERSION NUMBER
8602	03-M/I TRANSACTION CODE
8603	04-M/I PROCESSOR CONTROL NUMBER
8604	05-M/I PHARMACY NUMBER

Edit Number	Description
8605	06-M/I GROUP NUMBER
8606	07-M/I CARDHOLDER ID NUMBER
8607	08-M/I PERSON CODE
8608	09-M/I BIRTH DATE
8609	1C-M/I SMOKER/NON-SMOKER CODE
8610	1E-M/I PRESCRIBER LOCATION CODE
8611	10-M/I MEMBER GENDER CODE
8612	11-M/I MEMBER RELATIONSHIP CODE
8613	12-M/I MEMBER LOCATION
8614	13-M/I OTHER COVERAGE CODE
8615	14-M/I ELIGIBILITY CLARIFICATION CODE
8616	15-M/I DATE OF SERVICE
8617	16-M/I PRESCRIPTION/SERVICE REFERENCE NUMBER
8618	17-M/I FILL NUMBER
8619	19-M/I DAYS SUPPLY
8620	2C-M/I PREGNANCY INDICATOR
8621	2E-M/I PRIMARY CARE PROVIDER ID QUALIFIER
8622	20-M/I COMPOUND CODE
8623	21-M/I PRODUCT/SERVICE ID
8624	22-M/I DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE
8625	23-M/I INGREDIENT COST SUBMITTED
8626	25-M/I PRESCRIBER ID
8627	26-M/I UNIT OF MEASURE
8628	28-M/I DATE PRESCRIPTION WRITTEN
8629	29-M/I NUMBER REFILLS AUTHORIZED
8630	3A-M/I REQUEST TYPE
8631	3B-M/I REQUEST PERIOD DATE-BEGIN
8632	3C-M/I REQUEST PERIOD DATE-END
8633	3D-M/I BASIS OF REQUEST
8634	3E-M/I AUTHORIZED REPRESENTATIVE FIRST NAME
8635	3F-M/I AUTHORIZED REPRESENTATIVE LAST NAME
8636	3G-M/I AUTHORIZED REPRESENTATIVE STREET ADDRESS
8637	3H-M/I AUTHORIZED REPRESENTATIVE CITY ADDRESS
8638	3J-M/I AUTHORIZED REPRESENTATIVE STATE/PROVINCE ADDRESS
8639	3K-M/I AUTHORIZED REPRESENTATIVE ZIP/POSTAL ZONE
8640	3M-M/I PRESCRIBER PHONE NUMBER
8641	3N-M/I PRIOR AUTHORIZED NUMBER ASSIGNED
8642	3P-M/I AUTHORIZATION NUMBER

Edit Number	Description
8643	3R-PRIOR AUTHORIZATION NOT REQUIRED
8644	3S-M/I PRIOR AUTHORIZATION SUPPORTING DOCUMENTATION
8645	3T-ACTIVE PRIOR AUTHORIZATION EXISTS RESUBMIT AT EXPIRATION OF PRIOR AUTH
8646	3W-PRIOR AUTHORIZATION IN PROCESS
8647	3X-AUTHORIZATION NUMBER NOT FOUND
8648	3Y-PRIOR AUTHORIZATION DENIED
8649	32-M/I LEVEL OF SERVICE
8650	33-M/I PRESCRIPTION ORIGIN CODE
8651	34-M/I SUBMISSION CLARIFICATION CODE
8652	35-M/I PRIMARY CARE PROVIDER ID
8653	38-M/I BASIS OF COST
8654	39-M/I DIAGNOSIS CODE
8655	4C-M/I COORDINATION OF BENEFITS/OTHER PAYMENTS COUNT
8656	4E-M/I PRIMARY CARE PROVIDER LAST NAME
8657	40-PHARMACY NOT CONTRACTED WITH PLAN ON DATE OF SERVICE
8658	41-SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYER
8659	5C-M/I OTHER PAYER COVERAGE TYPE
8660	5E-M/I OTHER PAYER REJECT COUNT
8661	50-NON-MATCHED PHARMACY NUMBER
8662	51-NON-MATCHED GROUP ID
8663	52-NON-MATCHED CARDHOLDER ID
8664	53-NON-MATCHED PERSON CODE
8665	54-NON-MATCHED PRODUCT/SERVICE ID NUMBER
8666	55-NON-MATCHED PRODUCT PACKAGE SIZE
8667	56-NON-MATCHED PRESCRIBER ID
8668	57-NON-MATCHED P. A. /M. C. NUMBER
8669	58-NON-MATCHED PRIMARY PRESCRIBER
8670	6C-M/I OTHER PAYER ID QUALIFIER
8671	6E-M/I OTHER PAYER REJECT CODE
8672	60-PRODUCT/SERVICE NOT COVERED FOR MEMBER AGE
8673	61-PRODUCT/SERVICE NOT COVERED FOR MEMBER GENDER
8674	62-MEMBER/CARD HOLDER ID NAME MISMATCH
8675	63-INSTITUTIONALIZED MEMBER PRODUCT/SERVICE ID NOT COVERED
8676	64-CLAIM SUBMITTED DOES NOT MATCH PRIOR AUTHORIZATION
8677	65-MEMBER IS NOT COVERED
8678	66-MEMBER AGE EXCEEDS MAXIMUM AGE
8679	67-FILLED BEFORE COVERAGE EFFECTIVE
8680	68-FILLED AFTER COVERAGE EXPIRED

Edit Number	Description
8681	69-FILLED AFTER COVERAGE TERMINATED
8682	7C-M/I OTHER PAYER ID
8683	7E-M/I DUR/PPS CODE COUNTER
8684	70-PRODUCT/SERVICE NOT COVERED
8685	71-PRESCRIBER IS NOT COVERED
8686	72-PRIMARY PRESCRIBER IS NOT COVERED
8687	73-REFILLS ARE NOT COVERED
8688	74-OTHER CARRIER PAYMENT MEETS OR EXCEEDS PAYABLE
8689	75-PRIOR AUTHORIZATION REQUIRED
8690	76-PLAN LIMITATIONS EXCEEDED
8691	77-DISCONTINUED PRODUCT/SERVICE ID NUMBER
8692	78-COST EXCEEDS MAXIMUM
8693	79-REFILL TOO SOON
8694	8C-M/I FACILITY ID
8695	8E-M/I DUR/PPS LEVEL OF EFFORT
8696	80-DRUG-DIAGNOSIS MISMATCH
8697	81-CLAIM TOO OLD
8698	82-CLAIM IS POST-DATED
8699	83-DUPLICATE PAID/CAPTURED CLAIM
8700	84-CLAIM HAS NOT BEEN PAID/CAPTURED
8701	85-CLAIM NOT PROCESSED
8702	86-SUBMIT MANUAL REVERSAL
8703	87-REVERSAL NOT PROCESSED
8704	88-DUR REJECT ERROR
8705	89-REJECTED CLAIM FEES PAID
8706	90-HOST HUNG UP
8707	91-HOST RESPONSE ERROR
8708	92-SYSTEM UNAVAILABLE/HOST UNAVAILABLE
8709	95-TIME OUT
8710	96-SCHEDULED DOWNTIME
8711	97-PAYER UNAVAILABLE
8712	98-CONNECTION TO PAYER IS DOWN
8713	99-HOST PROCESSING ERROR
8714	AA-MEMBER SPENDDOWN NOT MET
8715	AB-DATE WRITTEN IS AFTER DATE FILLED
8716	AC-PRODUCT NOT COVERED NON-PARTICIPATING MANUFACTURER
8717	AD-BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLAIM TYPE
8718	AE-QMB (QUALIFIED MEDICARE BENEFICIARY)-BILL MEDICARE

Edit Number	Description
8719	AF-MEMBER ENROLLED UNDER MANAGED CARE
8720	AG-DAYS SUPPLY LIMITATION FOR PRODUCT/SERVICE
8721	AH-UNIT DOSE PACKAGING ONLY PAYABLE FOR NURSING HOME RECIPIENTS
8722	AJ-GENERIC DRUG REQUIRED
8723	AK-M/I SOFTWARE VENDOR/CERTIFICATION ID
8724	AM-M/I SEGMENT IDENTIFICATION
8725	A9-M/I TRANSACTION COUNT
8726	BE-M/I PROFESSIONAL SERVICE FEE SUBMITTED
8727	B2-M/I SERVICE PROVIDER ID QUALIFIER
8728	CA-M/I MEMBER FIRST NAME
8729	CB-M/I MEMBER LAST NAME
8730	CC-M/I CARDHOLDER FIRST NAME
8731	CD-M/I CARDHOLDER LAST NAME
8732	CE-M/I HOME PLAN
8733	CF-M/I EMPLOYER NAME
8734	CG-M/I EMPLOYER STREET ADDRESS
8735	CH-M/I EMPLOYER CITY ADDRESS
8736	CI-M/I EMPLOYER STATE/PROVINCE ADDRESS
8737	CJ-M/I EMPLOYER ZIP POSTAL ZONE
8738	CK-M/I EMPLOYER PHONE NUMBER
8739	CL-M/I EMPLOYER CONTACT NAME
8740	CM-M/I MEMBER STREET ADDRESS
8741	CN-M/I MEMBER CITY ADDRESS
8742	CO-M/I MEMBER STATE/PROVINCE ADDRESS
8743	CP-M/I MEMBER ZIP/POSTAL ZONE
8744	CQ-M/I MEMBER PHONE NUMBER
8745	CR-M/I CARRIER ID
8746	CW-M/I ALTERNATE ID
8747	CX-M/I MEMBER ID QUALIFIER
8748	CY-M/I MEMBER ID
8749	CZ-M/I EMPLOYER ID
8750	DC-M/I DISPENSING FEE SUBMITTED
8751	DN-M/I BASIS OF COST DETERMINATION
8752	DQ-M/I USUAL AND CUSTOMARY CHARGE
8753	DR-M/I PRESCRIBER LAST NAME
8754	DT-M/I UNIT DOSE INDICATOR
8755	DU-M/I GROSS AMOUNT DUE
8756	DV-M/I OTHER PAYER AMOUNT PAID

Edit Number	Description
8757	DX-M/I MEMBER PAID AMOUNT SUBMITTED
8758	DY-M/I DATE OF INJURY
8759	DZ-M/I CLAIM/REFERENCE ID
8760	EA-M/I ORIGINALLY PRESCRIBED PRODUCT/SERVICE CODE
8761	EB-M/I ORIGINALLY PRESCRIBED QUANTITY
8762	EC-M/I COMPOUND INGREDIENT COMPONENT COUNT
8763	ED-M/I COMPOUND INGREDIENT QUANTITY
8764	EE-M/I COMPOUND INGREDIENT DRUG COST
8765	EF-M/I COMPOUND DOSAGE FORM DESCRIPTIN CODE
8766	EG-M/I COMPOUND DISPENSING UNIT FORM INDICATOR
8767	EH-M/I COMPOUND ROUTE OF ADMINISTRATION
8768	EJ-M/I ORIGINALLY PRESCRIBED PRODUCT/SERVICE ID QUALIFIER
8769	EK-M/I SCHEDULED PRESCRIPTION ID NUMBER
8770	EM-M/I PRESCRIPTION/SERVICE REFERENCE NUMBER QUALIFIER
8771	EN-M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER
8772	EP-M/I ASSOCIATED PRESCRIPTION/SERVICE DATE
8773	ER-M/I PROCEDURE MODIFIER CODE
8774	ET-M/I QUANTITY PRESCRIBED
8775	EU-M/I PRIOR AUTHORIZATION TYPE CODE
8776	EV-M/I PRIOR AUTHORIZATION NUMBER SUBMITTED
8777	EW-M/I INTERMEDIARY AUTHORIZATION TYPE ID
8778	EX-M/I INTERMEDIARY AUTHORIZATION ID
8779	EY-M/I PROVIDER ID QUALIFIER
8780	EZ-M/I PRESCRIBER ID QUALIFIER
8781	E1-M/I PRODUCT/SERVICE ID QUALIFIER
8782	E3-M/I INCENTIVE AMOUNT SUBMITTED
8783	E4-M/I REASON FOR SERVICE CODE
8784	E5-M/I PROFESSIONAL SERVICE CODE
8785	E6-M/I RESULT OF SERVICE CODE
8786	E7-M/I QUANTITY DISPENSED
8787	E8-M/I OTHER PAYER DATE
8788	E9-M/I PROVIDER ID
8789	FO-M/I PLAN ID
8790	GE-M/I PERCENTAGE SALES TAX AMOUNT SUBMITTED
8791	HA-M/I FLAT SALES TAX AMOUNT SUBMITTED
8792	HB-M/I OTHER PAYER AMOUNT PAID COUNT
8793	HC-M/I OTHER PAYER AMOUNT PAID QUALIFIER
8794	HD-M/I DISPENSING STATUS

Edit Number	Description
8795	HE-M/I PERCENTAGE SALES TAX RATE SUBMITTED
8796	HF-M/I QUANTITY INTENDED TO BE DISPENSED
8797	HG-M/I DAYS SUPPLY INTENDED TO BE DISPENSED
8798	H1-M/I MEASUREMENT TIME
8799	H2-M/I MEASUREMENT DIMENSION
8800	H3-M/I MEASUREMENT UNIT
8801	H4-M/I MEASUREMENT VALUE
8802	H5-M/I PRIMARY CARE PROVIDER LOCATION CODE
8803	H6-M/I DUR CO-AGENT ID
8804	H7-M/I OTHER AMOUNT CLAIMED SUBMITTED COUNT
8805	H8-M/I OTHER AMOUNT CLAIMED SUBMITTED QUALIFIER
8806	H9-M/I OTHER AMOUNT CLAIMED SUBMITTED
8807	JE-M/I PERCENTAGE SALES TAX BASIS SUBMITTED
8808	J9-M/I DUR CO-AGENT ID QUALIFIER
8809	KE-M/I COUPON TYPE
8810	M1-MEMBER NOT COVERED IN THIS AID CATEGORY
8811	M2-RECIPIENT LOCKED IN
8812	M3-HOST PA/MC ERROR
8813	M4-PRESCRIPTION/SERVICE REFERENCE NUMBER/TIME LIMIT EXCEEDED
8814	M5-REQUIRES MANUAL CLAIM
8815	M6-HOST ELIGIBILITY ERROR
8816	M7-HOST DRUG FILE ERROR
8817	M8-HOST PROVIDER FILE ERROR
8818	ME-M/I COUPON NUMBER
8819	MZ-ERROR OVERFLOW
8820	NE-M/I COUPON VALUE AMOUNT
8821	NN-TRANSACTION REJECTED AT SWITCH OR INTERMEDIARY
8822	PA-PA EXHAUSTED/NOT RENEWABLE
8823	PB-INVALID TRANSACTION COUNT FOR THIS TRANSACTION CODE
8824	PC-M/I CLAIM SEGMENT
8825	PD-M/I CLINICAL SEGMENT
8826	PE-M/I COB/OTHER PAYMENTS SEGMENT
8827	PF-M/I COMPOUND SEGMENT
8828	PG-M/I COUPON SEGMENT
8829	PH-M/I DUR/PPS SEGMENT
8830	PJ-M/I INSURANCE SEGMENT
8831	PK-M/I MEMBER SEGMENT
8832	PM-M/I PHARMACY PROVIDER SEGMENT

Edit Number	Description
8833	PN-M/I PRESCRIBER SEGMENT
8834	PP-M/I PRICING SEGMENT
8835	PR-M/I PRIOR AUTHORIZATION SEGMENT
8836	PS-M/I TRANSACTION HEADER SEGMENT
8837	PT-M/I WORKERS COMPENSATION SEGMENT
8838	PV-NON-MATCHED ASSOCIATED PRESCRIPTION/SERVICE DATE
8839	PW-NON-MATCHED EMPLOYER ID
8840	PX-NON-MATCHED OTHER PAYER ID
8841	PY-NON-MATCHED UNIT FORM/ROUTE OF ADMINISTRATION
8842	PZ-NON-MATCHED UNIT OF MEASURE TO PRODUCT/SERVICE ID
8843	P1-ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER NOT FOUND
8844	P2-CLINICAL INFORMATION COUNTER OUT OF SEQUENCE
8845	P3-COMPOUND INGREDIENT COMPONENT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8846	P4-COORDINATION OF BENEFITS/OTHER PAYMENT COUNT DOES NOT MATCH NUMBEROF REPETITIONS
8847	P5-COUPON EXPIRED
8848	P6-DATE OF SERVICE PRIOR TO DATE OF BIRTH
8849	P7-DIAGNOSIS CODE COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8850	P8-DUR/PPS CODE COUNTER OUT OF SEQUENCE
8851	P9-FIELD IS NON-REPEATABLE
8852	RA-PA REVERSAL OUT OF ORDER
8853	RB-MULTIPLE PARTIALS NOT ALLOWED
8854	RC-DIFFERENT DRUG ENTITY BETWEEN PARTIAL AND COMPLETION
8855	RD-MISMATCHED CARDHOLDER/GROUP ID-PARTIAL TO COMPLETION
8856	RE-M/I COMPOUND PRODUCT ID QUALIFIER
8857	RF- IMPROPER ORDER OF DISPENSING STATUS CODE ON PARTIAL FILL TRANSACTION
8858	RG-M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON COMPLETION TRANSACTION
8859	RH-M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON COMPLETION TRANSACTION
8860	RJ-ASSOCIATED PARTIAL FILL TRANSACTION NOT ON FILE
8861	RK-PARTIAL FILL TRANSACTION NOT SUPPORTED
8862	RM-COMPLETION TRANSACTION NOT PERMITTED WITH SAME SERVICE DATE AS A PARTIAL TRANSACTION
8863	RN-PLAN LIMITS EXCEEDED ON INTENDED PARTIAL FILL VALUES
8864	RP-OUT OF SEQUENCE P REVERSAL ON PARTIAL FILL TRANSACTION
8865	RS-M/I ASSOCIATED PRESCRIPTION/SERVICE DATE ON PARTIAL TRANSACTION
8866	RT-M/I ASSOCIATED PRESCRIPTION/SERVICE REFERENCE NUMBER ON PARTIAL TRANSACTION

Edit Number	Description
8867	RU-MANDATORY DATA ELEMENTS MUST OCCUR BEFORE OPTIONAL ELEMENTS IN A SEGMENT
8868	R1-OTHER AMOUNT CLAIMED SUBMITTED COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8869	R2-OTHER PAYER REJECT COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8870	R3-PROCEDURE MODIFIER CODE COUNT DOES NOT MATCH NUMBER OF REPETITIONS
8871	R4-PROCEDURE MODIFIER CODE INVALID FOR PRODUCT/SERVICE ID
8872	R5-PRODUCT/SERVICE ID MUST BE ZERO WHEN PRODUCT/SERVICE ID QUALIFIER EQUALS 06
8873	R6-PRODUCT/SERVICE NOT APPROPRIATE FOR THIS LOCATION
8874	R7-REPEATING SEGMENT NOT ALLOWED IN SAME TRANSACTION
8875	R8-SYNTAX ERROR
8876	R9-VALUE IN GROSS AMOUNT DUE DOES NOT FOLLOW PRICING FORMULAE
8877	SE-M/I PROCEDURE MODIFIER CODE COUNT
8878	TE-M/I COMPOUND PRODUCT ID
8879	UE-M/I COMPOUND INGREDIENT BASIS OF COST DETERMINATION
8880	VE-M/I DIAGNOSIS CODE COUNT
8881	WE-M/I DIAGNOSIS CODE QUALIFIER
8882	XE-M/I CLINICAL INFORMATION COUNTER
8883	ZE-M/I MEASUREMENT DATE
8901	Other Commercial Insurance Response not received within 60 days for provider based bill.
8902	Other Medicare Part A Response not received within 60 days for provider based bill.
8903	Other Medicare Part B Response not received within 60 days for provider based bill.
8904	Other Medicare Managed Care Response not received within 120 days for provider based bill.
8999	Supersuspended For Missing Disposition
9000	Pricing Adjustment - The submitted charge exceeds the allowed charge. Claim paid at the program allowed amount.
9001	Pricing Adjustment - Reimbursement reduced by the member's copayment amount.
9002	Pricing Adjustment - Payment amount increased based on ambulatory surgery centers access payment policies.
9003	Pricing Adjustment - Third party liability amount applied is greater than the amount paid by the program.
9004	Pricing Adjustment - Amount paid is zero.
9006	Access payment included.
9007	Access payment not available for date of service on this date of process.
9008	Pricing Adjustment - Payment amount decreased based on Pay for Performance policy.
9020	Service paid in accordance with program requirements.
9801	Claim Paid At Per Diem Rate

Edit Number	Description
9802	Claim Paid at % of Billed Charges
9803	Pricing Adjustment - Medicare benefits are exhausted. Claim paid at program allowed rate.
9805	Pricing Adjustment - Payment reduced due to the inpatient or outpatient deductible.
9806	Pricing Adjustment - Payment reduced due to benefit plan limitations.
9807	Header Billing Provider used as Detail Performing Provider
9808	Header Performing Provider used as Detail Performing Provider
9809	Pricing Adjustment - Maximum Allowable Fee pricing used.
9816	Pricing Adjustment - Payment amount increased based on hospital access payment policies.
9902	Pricing Adjustment - Inpatient Per-Diem pricing.
9905	Pricing Adjustment - Medicare Pricing information
9906	Pricing Adjustment - Medicare pricing cutbacks applied.
9907	Pricing Adjustment - Third party liability deductible amount applied.
9908	PHARMACY PRICING APPLIED.
9909	Pricing Adjustment - Paid according to program policy.
9910	PHARMACY DISPENSING FEE APPLIED.
9911	Pricing Adjustment - Long Term Care pricing applied.
9912	Pricing Adjustment - Ambulatory Surgery pricing applied.
9914	Pricing Adjustment - Revenue code flat rate pricing applied.
9915	Pricing Adjustment - Medicare crossover claim cutback applied.
9916	Pricing Adjustment - Usual & Customary Charge (UCC) rate pricing applied.
9918	Pricing Adjustment - Maximum allowable fee pricing applied.
9919	Pricing Adjustment - Zero Paid Amount or Level of Care Pricing Applied.
9920	Pricing Adjustment - Resource Based Relative Value Scale (RBRVS) pricing applied.
9921	Pricing Adjustment - Prior Authorization pricing applied.
9922	Pricing Adjustment - Spenddown deductible applied.
9923	Pricing Adjustment - Member Liability deduction applied.
9926	Pricing Adjustment - Claim has pricing cutback amount applied.
9927	Reserved for Future Use.
9928	Pricing Adjustment - Amount paid is zero
9929	Pricing Adjustment - Anesthesia pricing applied.
9930	Pricing Adjustment - Priced per PETI Policy
9932	Pricing Adjustment - DRG pricing applied.
9933	Pricing Adjustment - Ambulatory Payment Classification (APC) pricing applied.
9935	Pricing Adjustment - Maximum Flat Fee pricing applied.
9936	Pricing Adjustment - Maximum Flat Fee Level 2 pricing applied.
9937	Pricing Adjustment - Usual & Customary Charge (UCC) flat fee pricing applied.
9938	Pricing Adjustment - Usual & Customary Charge (UCC) Flat Fee Level 2 pricing applied.

Edit Number	Description
9941	Pricing Adjustment--UB92 Hospice LTC Pricing
9942	Quantity reduced based on DHS policy
9944	Pricing Adjustment - Incentive Pricing
9945	Pricing Adjustment - Reimbursement for this claim is $0 due to either the Medicare allowed amount is greater than the Medicaid reimbursement amount or the total of the Medicare deductible, coinsurance or copayment is $0.
9946	Pricing Adjustment: Reimbursement amount is the difference between the Medicare allowed amount and the Medicaid reimbursement amount.
9947	Pricing Adjustment: Medicare Lower of Logic applied per Policy.
9953	HMO Encounter detail manually priced.
9955	Member is not enrolled in managed care.
9956	Services have been carved out of HMO encounter processing
9957	This service is not reimbursable for the managed care encounter claim for member's benefit plan.
9958	Member is not enrolled, therefore, the encounter cannot be processed
9960	Converted Claim paid with invalid/missing aid code.
9993	Internal-BP Processed and Denied Before Paying
9999	Processed Per Policy

Appendix R Revisions Log

Revision Date	Appendix	Pages	Made by
12/01/2016	*Updated for new Fiscal Agent*	*All*	*HPE*
12/27/2016	*No changes required in Colorado iC Stage II Provider Billing Manual Comment Log v0_2.xlsx*	*None*	*HPE*
1/10/2017	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_3.xlsx*	*multiple*	*HPE*
1/19/2017	*Updates based on Colorado iC Stage II Provider Billing Manual Comment Log v0_4.xlsx*	*Multiple*	*HPE*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE*

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.