

ODJFS ADJUSTMENT CODE OR LEGACY EOB CODE	"DRAFT" OHIO ADJUSTMENT OR LEGACY EOB CODE DESCRIPTION	HIPAA ADJUSTMENT REASON CODE OR (PLB SEGMENT CODE *)	HIPAA REMITTANCE ADVICE REMARK CODES
230	MEDICARE DEDUCTIBLE GREATER THAN ALLOWED DEDUCTIBLE.	1	N 18
A 56	ADJUSTMENT IS TO CORRECT AN ERROR MADE BY MEDICARE CONCERNING THE DEDUCTIBLE AMOUNT OWED BY MEDICAID.	1	
231	THE MEDICAID/MEDICARE CROSSOVER CLAIM BILLED A COINSURANCE AMOUNT WHICH IS GREATER THAN 20% OF THE APPROVED AMOUNT ENTERED ON THE CLAIM FORM. REVIEW COINSURANCE ENTERED ON THE CLAIM. FOR BILLING PSYCHOLOGY SERVICES REFER TO MAL 354 FOR PSYCHOLOGY OR 355 FOR PSYCHIATRIC SERVICES.	2	N 18
491	MODIFIER IS REQUIRED FOR THIS PROCEDURE CODE; SEE MEDICAID HANDBOOK FOR LIST OF VALID MODIFIERS.	4	
697	THE PROCEDURE CODE IS IN THE RANGE 99381 - 99385 OR 99391 - 99395 (HEALTHCHEK PROCEDURE CODES) AND THE PROCEDURE CODE MODIFIER IS MISSING OR IS NOT EQUAL TO AU, FA, FC, FR OR NF. RESUBMIT CLAIM WITH APPROPRIATE MODIFIER.	4	
287	PROCEDURE CODES 90935 THRU 90947 RENDERED IN PLACE OF SERVICE 03, 04 OR 05 ARE NOT COVERED FOR SERVICE DATES PRIOR TO 12/01/92.	5	
872	LINE ITEM PROCEDURE CODE IS NOT COVERED IN AN OUTPATIENT SETTING.	5	
873	A LINE ITEM CONTAINS A PROCEDURE CODE WHICH IS NOT COVERED IN AN OUTPATIENT SETTING.	5	
364	ACCORDING TO THE MEDICAID RECIPIENT FILE, THE RECIPIENT WITH THE BILLING NUMBER ENTERED ON THE CLAIM FORM WAS RESIDING IN A NURSING HOME FOR THE SERVICE DATE BILLED AND THE PROCEDURE CODE ENTERED ON THE CLAIM IS NOT PAYABLE FOR A RECIPIENT IN A NURSING HOME.	5	
365	THE TWO-DIGIT PLACE OF SERVICE CODE BILLED IS NOT ALLOWED FOR THE PROCEDURE CODE ENTERED ON THE CLAIM FORM. REVIEW THE PLACE OF SERVICE CODE AND PROCEDURE CODE FOR ACCURACY.	5	
443	SEX CONFLICT WITH PROCEDURE CODE #1 (CLINICAL EDITOR).	7	MA 66
557	SEX CONFLICT WITH PROCEDURE CODE #2 (CLINICAL EDITOR).	7	
558	SEX CONFLICT WITH PROCEDURE CODE #3 (CLINICAL EDITOR).	7	
369	AMBULATORY SURGICAL CENTER INDICATOR ON THE PDD FILE IS NOT EQUAL TO 1, 2, 3, 4, 5, 6, 7, OR 8.	8	
192	A MEDICAL SUPPLY CLAIM CAN ONLY CONTAIN HCPC MEDICAL SUPPLY, ORTHOTIC, PROSTHETIC AND DURABLE MEDICAL EQUIPMENT PROCEDURE CODES. CPT, DENTAL AND TRANSPORTATION PROCEDURE CODES SHOULD BE SUBMITTED ON APPROPRIATE INVOICES.	8	M 51

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332	THE PROCEDURE CODE BILLED ON THIS INVOICE IS NOT REIMBURSABLE FOR THE PROVIDER TYPE AS INDICATED BY THE SERVING PROVIDER NUMBER ENTERED ON THE INVOICE. VERIFY THE MEDICAID PROVIDER NUMBER ENTERED ON THE INVOICE FOR ACCURACY.	8	
544	AGE CONFLICT WITH DIAGNOSIS CODE #3 (CLINICAL EDITOR).	9	
239	ADMIT TYPE IS 4 (NEWBORN) AND THE RECIPIENT'S AGE IS GREATER THAN (0). CHECK RECIPIENT ID/ADMIT TYPE.	9	MA 41
323	RECIPIENT AGE IS LESS THAN MINIMUM AGE ON DIAGNOSIS MASTER OR GREATER THAN THE MAXIMUM AGE.	9	
543	AGE CONFLICT WITH DIAGNOSIS CODE #2 (CLINICAL EDITOR).	9	
545	AGE CONFLICT WITH DIAGNOSIS CODE #4 (CLINICAL EDITOR).	9	
546	AGE CONFLICT WITH DIAGNOSIS CODE #5 (CLINICAL EDITOR).	9	
435	THIS IS A CLINICAL EDITOR ERROR. ACCORDING TO THE MEDICAID RECIPIENT NUMBER ENTERED ON THE CLAIM FORM, THE AGE OF THE RECIPIENT CONFLICTS WITH THE PRINCIPAL DIAGNOSIS CODE BILLED ON THE CLAIM FORM. REVIEW THE 12 DIGIT MEDICAID RECIPIENT NUMBER AND THE DIAGNOSIS CODE FOR ACCURACY.	9	
324	THE DIAGNOSIS CODE WHICH WAS BILLED IS INAPPROPRIATE FOR THE RECIPIENT'S SEX. REVIEW THE DIAGNOSIS CODE AND RECIPIENT NUMBER ENTERED ON THE CLAIM FORM FOR ACCURACY.	10	
540	SEX CONFLICT WITH DIAGNOSIS CODE #3 (CLINICAL EDITOR).	10	
539	SEX CONFLICT WITH DIAGNOSIS CODE #2 (CLINICAL EDITOR).	10	
542	SEX CONFLICT WITH DIAGNOSIS CODE #5 (CLINICAL EDITOR).	10	
541	SEX CONFLICT WITH DIAGNOSIS CODE #4 (CLINICAL EDITOR).	10	
458	DRG 468-PROCEDURE AND DIAGNOSIS ARE NOT COMPATIBLE, THE CLAIM MUST HAVE CONDITION CODE 98.	11	
490	ORGAN TRANSPLANT; SERVICE REQUIRES AUTHORIZATION AND NO AUTHORIZATION ON FILE.	15	
602	CLAIM RECIPIENT NUMBER DOES NOT MATCH PRIOR AUTHORIZATION RECIPIENT NUMBER.	15	
340	BILLED SERVICE MAY REQUIRE PRIOR AUTHORIZATION, RE-CHECK FORMULARY FOR COVERAGE FIRST; FLU VACCINE AND IRRIGATION SOLUTIONS BILLABLE ON "9999" CODES; FES04 MUST BE ENTERIC COATED; MEDICAL SUPPLIES ARE NOT BILLABLE ON DRUG INVOICE; PACKAGE SIZE, STRENGTH, OR NDC MAY NOT BE ON FORMULARY.	15	

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511	THE PROCEDURE OR DRUG CODE ENTERED ON THE CLAIM DOES NOT MATCH THE PROCEDURE/DRUG CODE THAT WAS AUTHORIZED UNDER THE PRIOR AUTHORIZATION NUMBER THAT WAS BILLED ON THE CLAIM FORM.	15	
514	PRIOR AUTHORIZATION LINE NUMBER NOT APPROVED.	15	
518	AUTHORIZATION REQUEST HAS NOT BEEN APPROVED. APPROVAL STILL PENDING OR REQUEST WAS DEFERRED.	15	M 62
353	THE PROCEDURE/DRUG CODE ENTERED ON THE CLAIM REQUIRES PRIOR AUTHORIZATION AND THE PRIOR AUTHORIZATION NUMBER IS MISSING FROM THE CLAIM FORM. REVIEW THE PROCEDURE/DRUG CODE BILLED FOR ACCURACY. IF PROCEDURE/DRUG IS CORRECT, REQUEST PRIOR AUTHORIZATION FOR THE SERVICE BILLED.	15	
394	NON-EMERGENCY TRANSPORTATION OVER 50 MILES WITH PRIOR AUTHORIZATION NUMBER MISSING OR INVALID.	15	
513	CLAIM SERVICE DATE EXCEEDS PRIOR AUTHORIZATION EXPIRATION DATE. A NEW PA REQUEST MUST BE MADE.	15	
500	CLAIM PRIOR AUTHORIZATION NUMBER NOT ON PA FILE. PLEASE CONTACT THE MEDICAL OPERATION SECTION AT 614-466-6065 FOR ASSISTANCE.	15	
172	THE PROCEDURE CODE IS MISSING FROM THE CLAIM FORM. TO CORRECT, ENTER THE 5-DIGIT PROCEDURE CODE AND RESUBMIT A NEW CLAIM FORM.	16	M 20
148	FOR UB82 OR UB92 THE LINE ITEM REVENUE CODE IS MISSING FOR THE SERVICE BILLED.	16	M 50
124	DATE OF SERVICE ON CLAIM OR LINE ITEM IS INVALID OR MISSING.	16	MA 06
139	FOR UB82 OR UB92 A PROCEDURE CODE(S) WAS ENTERED TO IDENTIFY THE SURGICAL OB OR MEDICAL PROCEDURE PERFORMED AND BOTH THE "ATTENDING PHYSICIAN" AND "OTHER PHYSICIAN" MEDICAID PROVIDER NUMBERS ARE MISSING FROM THE SUBMITTED INVOICE.	16	MA 102
190	FOR UB82 OR UB92 THE TYPE OF ADMISSION IS MISSING FROM THE INVOICE. REFER TO THE MEDICAID HOSPITAL HANDBOOK FOR PROPER BILLING INSTRUCTIONS.	16	MA 41
185	ADMISSION DATE IS MISSING OR INVALID.	16	MA 40
312	THIS CLAIM IS MISSING THE INDIVIDUAL PROVIDER NUMBER IN ITEM 2 OF THE ODHS 6780 OR THE SPACE LABELED "PIN" ITEM 33 OF THE HCFA 1500. SEE BILLING INSTRUCTIONS FOR PROPER ENTRY.	16	MA 82

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160	A THIRD PARTY INSURANCE IDENTIFIER WAS BILLED ON THE INVOICE TO DENOTE THAT PAYMENT WAS RECEIVED BUT THE THIRD PARTY PAYMENT IS MISSING FROM THE INVOICE. FOR UB82/92, REVIEW PRIOR PAYMENT BLOCK. FOR 6780, 6746 AND THE HCFA 1500 INVOICES, REVIEW THE OTHER SOURCE AMOUNT BLOCK.	16	MA 92
203	A VALUE CODE AMOUNT IS GREATER THAN (0) ZERO AND ITS ASSOCIATED VALUE CODE IS MISSING/INVALID. TO CORRECT, ENTER A VALID VALUE IN THE VALUE CODE FIELD OR REMOVE THE VALUE CODE AMOUNT IF IT WAS LISTED IN ERROR.	16	MA 49
488	ENCOUNTER CODE (W0020) IS MISSING. REQUIRED FOR PROVIDER TYPE 05, RURAL HEALTH FACILITY CLAIMS.	16	
132	TOTAL CLAIM CHARGE IS MISSING OR INVALID OR FOR MEDICARE/ MEDICAID CROSSOVER CLAIMS THE MEDICARE APPROVED AMOUNT IS MISSING.	16	M 54
129	THE RECIPIENT'S BILLING NUMBER IS MISSING FROM THE INVOICE. FOR THE 6780 THIS IS BLOCK 9. FOR THE 6746 PHARMACY INVOICE THIS IS BLOCK 13. FOR THE UB82-UB92 THIS BLOCK IS LABELED CERT-SSN-HIC-ID NO. FOR THE HCFA 1500 THIS IS BLOCK 1A.	16	MA 61
228	A MEDICARE/MEDICAID CROSSOVER INVOICE WAS PROCESSED AND THE MEDICARE PAYMENT DATE IS MISSING. THE MEDICARE PAYMENT DATE SUBMITTED TO THE DEPARTMENT MUST MATCH THE PAY DATE AS SHOWN ON THE MEDICARE REMITTANCE ADVICE/MEDICARE SUMMARY NOTICE.	16	
359	PROCEDURE INDICATES ABORTION; CERTIFICATION STATEMENT IS MISSING OR INVALID. CPT CODES 59105, 59106, 59840, 59841, 59850-59852 AND ICD-9 PROCEDURES 6901, 6951, 7491 AND 750 ARE ABORTIONS. IF SERVICE IS NOT AN ABORTION, CHOOSE A DIFFERENT CODE. OTHERWISE RESUBMIT WITH CERTIFICATION.	16	N 3
345	HYSTERECTOMY/STERILIZATION CONSENT FORM INCOMPLETE OR IMPROPERLY SUBMITTED. NO CONSENT DATE ENTERED.	16	N 3
397	DIAGNOSIS INDICATES STERILIZATION AND NO CONSENT DATE WAS	16	N 3
184	LINE ITEM SUBMITTED CHARGE IS MISSING OR INVALID.	16	M 54
358	PROCEDURE INDICATES HYSTERECTOMY AND NO CONSENT FORM WAS RECEIVED.	16	N 3
380	REVENUE CODE INDICATES ABORTION; THE CERTIFICATION STATEMENT IS MISSING/INVALID. (SEE MAL 115).	16	N 3
131	THE PRESCRIBING PHYSICIAN NUMBER ENTERED IN BLOCK 15 OF THE 6746 INVOICE IS INCORRECT. REVIEW THE PHYSICIAN PROVIDER NUMBER THAT WAS ENTERED ON THE CLAIM FOR ACCURACY.	47	

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426	FOR UB82 OR 8B92 ONE OR MORE PROCEDURE CODES WERE ENTERED IN THE PROCEDURE CODE BLOCKS INDICATING THAT A SURGICAL PROCEDURE WAS PERFORMED AND THE SEVEN DIGIT MEDICAID PROVIDER NUMBER IS MISSING FROM THE OTHER PHYSICIAN ID BLOCK.	17	M68
512	THE SERVICE DATE ENTERED ON THE CLAIM FORM DOES NOT FALL WITHIN THE DATE OF SERVICE SPAN ASSIGNED TO THE PRIOR AUTHORIZATION NUMBER WHICH WAS ENTERED ON THE CLAIM FORM. CHECK THE DATE OF SERVICE AND THE PRIOR AUTHORIZATION NUMBER ON THE CLAIM FORM FOR	17	
392	SERVICE REQUIRES REFERRING PROVIDER.	17	M 68
888	FOR OP CLAIMS AFTER 06/30/88, PROCEDURE CODE REQUIRED FOR LINE ITEM REVENUE CODE.	17	M 51
886	FOR OP CLAIMS AFTER 06/30/88, LINE ITEM DATE OF SERVICE MUST BE PRESENT.	17	
877	QUANTITY INCORRECT, LIST QUANTITY AS # OF BOTTLES, TUBES, VIALS OR PACKAGES. DO NOT USE ML, CC OR OZ.	17	
356	THE PROCEDURE CODE REQUIRES A TOOTH SURFACE AND NONE WAS	17	N 81
355	ENTRY ON CLAIM FOR TOOTH NUMBER IS INVALID.	17	N 37
354	FOR THE PROCEDURE CODE THAT WAS ENTERED ON THE CLAIM FORM, A TOOTH NUMBER IS REQUIRED AND NONE WAS ENTERED IN COLUMN "F" OF THE 6780 CLAIM FORM. VALID TOOTH NUMBERS ARE: 01-32 OR A-T.	17	N 37
164	FOR UB 82 AND UB92 THE SOURCE OF ADMISSION CODE IS MISSING ON THE SUBMITTED INVOICE. REFER TO THE MEDICAID HOSPITAL HANDBOOK FOR PROPER BILLING INSTRUCTIONS.	17	MA 42
980	A RELATED SERVICE RENDERED FOR THIS ENCOUNTER WAS REJECTED. SEE LINE ITEM EOB FOR DENIAL REASON.	17	
121	THE SERVICING MEDICAID PROVIDER NUMBER IS MISSING FROM THE INVOICE. FOR THE 6780 THIS IS BLOCK 2. FOR THE HCFA 1500 THIS IS THE SPACE LABELED "PIN" IN BLOCK 33.	17	M 68
896	INVALID HOME HEALTH LATE CHARGE (TYPE BILL 335); NO PAID CLAIM WITH TYPE BILL 331, 332, 333 OR 334 FOR THE SAME DATE(S) OF SERVICE COULD BE FOUND ON OUR HISTORY FILES. LATE CHARGE SERVICE DATES MUST FALL WITHIN OR BE EQUAL TO SERVICE DATES OF A PAID CLAIM WITH ONE OF THESE BILL TYPES.	17	MA 30
246	THE OTHER SOURCE AMOUNT IS GREATER THAN \$0.00 AND THE OTHER SOURCE INDICATOR IS MISSING.	17	MA 92
940	MISSING OR INVALID DAYS SUPPLY (NCPDP EDIT 19, FIRST HEALTH POS EDIT 026).	17	

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944	MISSING/INVALID METRIC DECIMAL QUANTITY (NCPDP EDIT E7, FIRST HEALTH POS EDIT 037).	47	
978	FOR DATES OF SERVICE ON AND AFTER 5/1/01, THE FOLLOWING ANESTHESIA MODIFIERS ARE VALID FOR PHYSICIAN PROVIDERS:M AA, AD, QK, QY. CRNAS MAY BILL QX OR QZ ANESTHESIA MODIFIERS. ANESTHESIOLOGY ASSISTANTS MAY BILL QX.	17	M 78
280	FOR UB82 OR UB92 A PRIOR PAYMENT AMOUNT WAS ENTERED IN THE PRIOR PAYMENTS BLOCK AND THE THREE DIGIT PAYER IDENTIFICATION CODE ENTERED WAS A PAYER CODE OTHER THAN 200,300, 400, 500 OR 900. REFER TO THE APPROPRIATE HANDBOOK FOR PROPER BILLING INSTRUCTIONS.	17	MA 92
990	A LINE ITEM ON THIS CLAIM FOR THE SAME DATE OF SERVICE CONTAINS ERRORS REQUIRING CORRECTION.	17	
222	POSSIBLE CONFLICT, DIFFERENT CLAIM TYPES.	18	
A 53	A MEDICARE CROSSOVER CLAIM - MORE THAN ONE PAYMENT HAS BEEN MADE FOR THE CLAIM OR THE LINE ITEM SERVICE.	18	
704	THIS CLAIM IS A POSSIBLE DUPLICATE OF AN ALREADY PAID CLAIM. THE PAID REFERENCE LINE NUMBER CORRESPONDING TO THIS REJECTION IDENTIFIES WHERE THE INFORMATION FOR THE PREVIOUSLY PAID CLAIM CAN BE FOUND ON THE LAST PAGE OF THIS REMITTANCE ADVICE.	18	
A 16	THE CLAIM OR LINE ITEM PAYMENT HAS BEEN PAID BY MEDICAID MORE THAN ONCE.	18	
A 17	MORE THAN ONE DEDUCTION HAS BEEN PROCESSED FOR A CLAIM OR LINE ITEM, LEAVING AN UNDERPAYMENT TO THE PROVIDER.	18	
492	EXACT DUPLICATE - OUTPATIENT LATE CHARGES	18	
493	POSSIBLE DUPLICATE - OUTPATIENT LATE CHARGES. ONLY TWO TYPE 135 BILLS PERMITTED PER SERVICE DATE.	18	
101	THIS CLAIM IS AN EXACT DUPLICATE SUBMISSION FOR A CLAIM WHICH HAS ALREADY PAID. FOR THIS REMITTANCE ADVICE, NOTE THE PAID REFERENCE LINE CORRESPONDING TO THE DUPLICATE CLAIM REJECTION. USING THE PAID REFERENCE LINE NUMBER REFER TO THE LAST PAGE OF THIS RA FOR CLAIM PAYMENT INFORMATION.	18	
640	DUPLICATE KEY (NCPDP EDIT 83, FIRST HEALTH POS EDIT 126).	48	
259	THE 12 DIGIT BILLING NUMBER THAT WAS ENTERED ON THE INVOICE IS ALSO ELIGIBLE FOR MEDICARE PART A FOR THE DATE OF SERVICE BILLED ON THE INVOICE. SUBMIT THE INVOICE TO MEDICARE FIRST. IF DENIED BY MEDICARE ATTACH THE MEDICARE DENIAL TO THE INVOICE AND ODHS 6653, THEN SUBMIT TO PROVIDER RELATIONS.	22	N 18

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261	THE 12 DIGIT BILLING NUMBER THAT WAS ENTERED ON THE CLAIM IS ALSO ELIGIBLE FOR MEDICARE PART B FOR THE SERVICE DATE BILLED. SUBMIT THE CLAIM TO MEDICARE FIRST. IF DENIED BY MEDICARE, ATTACH THE MEDICARE DENIAL TO THE CLAIM AND ODHS 6653 INQUIRY FORM, THEN SEND TO PROVIDER RELATIONS.	22	N 18
A 39	USED FOR HEALTH MANAGEMENT SYSTEMS RECOUPMENTS WHEN HMS HAS DISCOVERED /RECOVERED MEDICAID OVERPAYMENT RELATIVE TO MEDICARE PART A, B, OR OTHER INSURANCE.	22	
234	FOR COMMON CLAIM MEDICARE CROSSOVERS; THE SUM OF CASH DEDUCTIBLE AND COINSURANCE EQUALS \$0.00. FOR UB82 INPATIENT/OUTPATIENT CROSSOVERS; THE SUM OF COINSURANCE, BLOOD AND CASH DEDUCTIBLES EQUALS \$0.00. CLAIM WAS EITHER TOTALLY DENIED OR 100% PAID BY MEDICARE. SEE MEDICARE EOMB FOR STATUS.	22	N 18
260	THE 12 DIGIT BILLING NUMBER ENTERED ON THE INVOICE IS ALSO ELIGIBLE FOR MEDICARE PART B FOR THE DATE OF SERVICE BILLED. SUBMIT THE CLAIM TO MEDICARE PRIOR TO BILLING THE DEPARTMENT. IF DENIED BY MEDICARE, ATTACH THE MEDICARE DENIAL TO THE CLAIM AND ODHS 6653 INQUIRY FORM, THEN SEND TO PROVIDER RELATIONS.	22	N 18
A 13	THE PATIENT HAS MEDICARE COVERAGE FOR THE CLAIM SERVICE DATES.	22	N 18
406	BILL MEDICARE (NCPDP EDIT 70, FIRST HEALTH POS EDIT 192).	22	
219	OTHER INSURANCE INDIC IS "R" OR OCCURRENCE CODE = 51; CLAIM RECEIVED PRIOR TO THE 91 DAY FILING LIMIT.	22	
A 27	THE THIRD PARTY SECTION HAS DISCOVERED EXISTING INSURANCE COVERAGE FOR THE CLAIM DATES OF SERVICE.	22	MA 92
218	ACCORDING TO THE DEPARTMENT'S ELIGIBILITY FILE, THE RECIPIENT WITH THE NUMBER THAT WAS ENTERED ON THE CLAIM FORM IS COVERED BY ANOTHER INSURANCE SOURCE FOR THE DATE OF SERVICE BILLED AND NO THIRD PARTY PAYMENT AMOUNT WAS ENTERED ON THE CLAIM FORM. BILL OTHER INSURER PRIOR TO BILLING ODJFS.	22	MA 92
A 28	THE THIRD PARTY SECTION HAS DISCOVERED AN OVERPAYMENT DUE TO PROVIDER COLLECTION FROM AN INSURANCE CARRIER.	23	M 43
A 11	THE PROVIDER HAS RECEIVED PAYMENT FORM A THIRD PARTY SOURCE SUBSEQUENT TO THE MEDICAID PAYMENT.	23	
509	TPL AMOUNT GREATER THAN BILLED (NCPDP EDIT #, FIRST HEALTH POS EDIT #033).	23	
417	TPL INDICATORS CONFLICT (NCPDP EDIT DV, FIRST HEALTH POS EDIT 204).	23	

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927	PATIENT IS A PACE PROGRAM ENROLLEE AT EITHER CONCORDIA CARE (216-791-3580) OR TRIHEALTH SENIOR (513-745-1876). PACE IS A FULLY CAPITATED MEDICAID/MEDICARE MANAGED CARE DEMONSTRATION PROGRAM. CONTRACT LOCAL PACE PROVIDER FOR PAYMENT.	24	M 115
A 19	THE ADJUSTMENT IS TO PAY A HEALTH MAINTENANCE ORGANIZATION.	24	
A 20	THE ADJUSTMENT IS TO CORRECT AN ERROR MADE INVOLVING A CAPITATION RATE TO A HEALTH MAINTENANCE ORGANIZATION.	24	
A 34	THE RECIPIENT IS COVERED BY A HEALTH MAINTENANCE ORGANIZATION.	24	
A 36	USED FOR MATERNITY PAYMENT RECOUPMENTS.	24	
308	THE TWELVE DIGIT BILLING NUMBER ENTERED ON THE INVOICE IS ENROLLED IN AN HMO. THE PROCEDURE CODE ENTERED ON THE CLAIM FORM ARE COVERED BY THIS HEALTH PLAN. BILL THE HEALTH PLAN (HMO) THAT IS IDENTIFIED ON YOUR REMITTANCE ADVICE.	24	
276	THE DATE OF SERVICE FOR THIS CLAIM IS OVER 365 DAYS OLD AND THE DATE THE DEPARTMENT RECEIVED THIS CLAIM WAS MORE THAN 180 DAYS FROM MEDICARE'S PAID DATE AS INDICATED ON THE MEDICARE REMITTANCE	29	
305	THE SERVICE DATE ENTERED ON THE CLAIM FORM IS OVER TWO YEARS OLD. REVIEW THE D.O.S. ENTERED ON THE CLAIM FOR ACCURACY. THE DEPT'S CLAIM FILING DEADLINE FOR COMMON, DRUG, AND EPSDT IS 365 DAYS FROM THE FIRST SERVICE DATE ON THE CLAIM. FOR THE UB82/UB92, 365 DAYS FROM THE DISCHARGE DATE.	29	
120	THIS CLAIM WAS RECEIVED BY THE DEPARTMENT AFTER THE 365 DAY CLAIM FILING LIMITATION WAS EXCEEDED. THE CLAIM REQUIRES DOCUMENTATION (I.E. TRANSACTION CONTROL NUMBER) TO SUPPORT A TIMELY SUBMISSION EFFORT WITHIN THE 365 DAY TIME FRAME. SEND TO THE BUREAU OF PROVIDER RELATIONS.	29	
290	BEGINNING DATE OF SERVICE MORE THAN 10 YEARS OLD OR EQUAL TO ZERO. TAPE PROVIDERS BILL HARDCOPY.	29	
225	UB82 LAST DATE OF SERVICE OR NON-UB82 FIRST DATE OF SERVICE IS GREATER THAN MENTAL HEALTH FILING LIMIT.	29	
951	FOR OUTPATIENT CLAIMS; THE LINE ITEM DATE OF SERVICE OR THE DATE OF DISCHARGE IS OVER 2 YEARS OLD.	29	
257	THE RECIPIENT IS ON REVIEW.	30	
647	BENEFIT RECORD NOT FOUND (NCPDP EDIT 51, FIRST HEALTH POS EDIT 165).	34	

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250	THE 12 DIGIT BILLING NUMBER ENTERED ON THE INVOICE IS NOT ON THE DEPARTMENT'S ELIGIBILITY FILE. REFER TO THE PATIENT'S MEDICAL CARD BILLING NUMBER FOR ACCURATE INFORMATION OR CONTACT THE COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES.	31	MA 61
423	PROVIDER IS NOT A MEMBER OF PAYEE'S GROUP.	38	
474	REQ LA MET, RPH CALL 877-518-1546 (NCPDP EDIT 75, FIRST HEALTH POS EDIT 207).	39	
895	QUANTITY TO LARGE TO COMPUTE REIMBURSEMENT. QUANTITY MUST REFLECT PRESCRIBED UNITS OF SERVICE FOR PROCEDURE.	42	
552	INVALID 4TH OR 5TH DIGIT FOR DIAGNOSIS CODE #3 (CLINICAL EDITOR).	47	
551	INVALID 4TH OR 5TH DIGIT FOR DIAGNOSIS CODE #2 (CLINICAL EDITOR).	47	
163	NO DIAGNOSIS CODE WAS ENTERED ON THE CLAIM FORM. DETERMINE THE CORRECT DIAGNOSIS CODE AND ENTER IT IN THE APPROPRIATE BLOCK OF THE CLAIM. REFER TO BILLING INSTRUCTIONS.	47	MA 63
427	PRESCRIBING PHYSICIAN IS NOT EQUAL TO PROVIDER TYPE 01, 02, 07, 20, 21, 22, 23, 30, 31, 35, 36, 55, 61 OR 62.	52	
301	THE SERVICING PROVIDER NUMBER ENTERED ON THE CLAIM DOES NOT HAVE THE CATEGORY OF SERVICE IN THEIR PROVIDER RECORD THAT IS NEEDED FOR THE BILLED PROCEDURE AND SERVICE DATES ENTERED ON THE CLAIM. CONTACT THE PROVIDER ENROLLMENT UNIT TO VERIFY YOUR ASSIGNED CATEGORY-OF-SERVICE.	52	
420	THE RECIPIENT IS ENROLLED IN THE P.A.C.T. PROGRAM. FOR PHARMACY CLAIMS; THE PHARMACY PROVIDER # IS NOT THE DESIGNATED PHARMACY FOR PHYSICIAN CLAIMS; THE SERVICING AND/OR REFERRING PHYSICIAN PROVIDER # IS NOT LISTED AS THE DESIGNATED PHYSICIAN FOR THIS RECIPIENT AND SERVICE DATE(S).	52	
303	PROVIDER TYPES 01, 02 AND 03 ARE NOT ALLOWED TO BILL THE PROFESSIONAL COMPONENT MODIFIER.	52	
914	IN RESPONSE TO YOUR RECENT NOTIFICATION TO THE DEPARTMENT, YOUR MEDICAID PROVIDER NUMBER HAS BEEN PLACED IN A VOLUNTARY TERMINATION STATUS.	52	
288	THE REFERRING PROVIDER ON THE CLAIM HAS NO CORRESPONDING RECORD ON THE PROVIDER MASTER FILE.	52	MA 102 M 68
429	PROVIDER IS A NURSE MIDWIFE AND REFERRING PROVIDER IS NOT AN MD OR DO.	52	
302	THE PRESCRIBING PHYSICIAN HAS NO RECORD ON THE PROVIDER MASTER	52	

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313	YOUR CATEGORY OF SERVICE LISTED IN OUR DEPARTMENT'S PROVIDER MASTER FILE WILL NOT ALLOW THE PROCESSING OF THIS CLAIM. ADDITIONAL/UPDATES ON YOUR CATEGORY OF SERVICE ARE NEEDED. CONTACT PROVIDER ENROLLMENT AT 1-800-686-6108 (INSTATE; 614-728-3288 (OUT-OF-STATE).	52	
384	REVENUE CODE IS NOT ALLOWED FOR A RECIPIENT RESIDING IN A NURSING HOME.	58	M 77
170	THE TWO-DIGIT PLACE OF SERVICE IS INCORRECT. REFER TO YOUR MEDICAID HANDBOOK FOR VALID PLACE OF SERVICE CODES AND PROPER BILLING INSTRUCTIONS.	58	M 77
306	PLACE OF SERVICE IS NOT EQUAL TO "08" AND THE SERVICING PROVIDER IS AN AMBULATORY SURGERY CENTER.	58	M 77
705	MULTIPLE SURGERIES REPORTED, CLAIM MUST BE SUBMITTED HARD COPY.	59	
869	SURGERY CODES (10000-69999) MUST BE ACCOMPANIED BY AN ANESTHESIA CODE (00100-01999). NO SUCH CODE IS PRESENT IN THE CLAIM RECORD WHOSE DATE OF SERVICE IS THE SAME AS THE DATE THE SURGERY WAS	59	
879	MULTIPLE ANESTHESIA SERVICES RENDERED ON THE SAME DAY FOR THE SAME RECIPIENT. (SEE 2ND EOB)	59	N 20
878	MULTIPLE ASSISTANT SURGEON PROCEDURES RENDERED ON THE SAME DAY FOR THE SAME RECIPIENT. (SEE 2ND EOB).	59	N 20
503	PA NUMBER WAS USED ON A PREVIOUSLY PAID CLAIM. AUTHORIZED SERVICES, UNITS AND DOLLARS EXHAUSTED.	62	
191	FOR UB82 OR UB92 THE TYPE OF ADMISSION BILLED WAS CODED AS A "3" ELECTIVE AND THE PREADMISSION CERTIFICATION NUMBER IS MISSING FROM THE TREATMENT AUTHORIZATION CODE BLOCK.	62	
870	THE OUTPATIENT SURGERY INDICATED REQUIRES PRIOR AUTHORIZATION. NO PA IS ON FILE.	62	
501	CLAIM PRIOR AUTHORIZATION NUMBER IS NOT APPROVED.	62	
530	UNITS BILLED EXCEEDS APPROVED/REMAINING UNITS, SEE PRIOR AUTHORIZATION FOR PROPER UNITS OF SERVICE.	62	
611	CLAIM PROCEDURE OR DRUG CODE NOT AUTHORIZED.	62	
515	PA LINE ITEM WAS USED ON A PREVIOUS PAID CLAIM. AUTHORIZED SERVICE, UNITS AND DOLLARS EXHAUSTED.	62	
612	CLAIM SERVICE DATES DO NOT FALL WITHIN PRIOR AUTHORIZATION LINE ITEM EFFECTIVE DATES.	62	
615	CLAIM PRIOR AUTHORIZATION LINE NUMBER DOES NOT EXIST IN THE PA RECORD.	62	

ODJFS ADJUSTMENT CODE OR LEGACY EOB CODE	"DRAFT" OHIO ADJUSTMENT OR LEGACY EOB CODE DESCRIPTION	HIPAA ADJUSTMENT REASON CODE OR (PLB SEGMENT CODE *)	HIPAA REMITTANCE ADVICE REMARK CODES
616	CLAIM PRIOR AUTHORIZATION PRICE PER UNIT DOES NOT EQUAL THE PA PRICE PER UNIT.	62	
502	CLAIM RECIPIENT NUMBER DOES NOT MATCH PA RECIPIENT NUMBER.	62	
991	SURGICAL PROC REQUIRES AUTHORIZATION. TREATMENT AUTHORIZATION NUMBER IS MISSING ON CLAIM FORM OR INVALID. CONTACT BUREAU OF MEDICAL OPERATIONS TO REQUEST PRIOR AUTHORIZATION FOR THE PROCEDURE BILLED.	62	
A 52	ADJUSTMENT IS TO CORRECT AN ERROR MADE BY MEDICARE CONCERNING BLOOD DEDUCTIBLE AMOUNT OWED BY MEDICAID.	66	
A 40	THE ADJUSTMENT IS TO REIMBURSE THE PROVIDER FOR THE COST OF REPLACING BLOOD.	66	
A 01	PAYMENT IS INCORRECT DUE TO MISCALCULATION IN DAY OUTLIER AMOUNT OR DAY OUTLIER AMOUNT IS NOT PAID.	69	
A 03	THE CLAIM IS PAID THROUGH THE ADJUSTMENT SECTION AS AN EXCEPTIONAL COST OUTLIER PAYMENT.	70	
A 95	LTCF HOSPITAL COVERED LEAVE DAYS REIMBURSED AT 50% OF THE PER DIEM RATE.	78	
A 96	LTCF COMBINATION OF THERAPEUTIC AND HOSPITAL COVERED LEAVE DAYS REIMBURSED AT 50% OF THE PER DIEM RATE OR NON-SPECIFIC COVERED LEAVE DAYS.	78	
A 94	LTCF THERAPEUTIC COVERED LEAVE DAYS REIMBURSED AT 50% OF THE PER DIEM RATE.	78	
A 70	LTCF RECOUPMENT OF OVERPAID NONCOVERED LEAVE DAYS.	78	N 43
141	FOR UB82 OR UB92 THE SUM OF THE COVERED DAYS AND NONCOVERED DAYS DOES NOT EQUAL THE STATEMENT COVERS PERIOD AS BILLED ON THE INVOICE. REVIEW SUBMITTED DATA FOR ACCURACY.	78	MA 32 MA 33
A 71	LTCF RECOUPMENT OF OVERPAID DAYS TO THE PROVIDER.	78	
CC	GROSS CREDIT IS A RECOUPMENT OF INTEREST OVERPAYMENT.	85	
A 83	LTCF PAYMENT RECEIVED FROM PROVIDER, WHICH IS NOT RECIPIENT	88	
A 37	USED FOR FIRST HEALTH POS (POINT OF SALE) VOIDS.	91	
350	THE MANUALLY ENTERED ALLOWED CHARGE EXCEEDS THAT AMOUNT	94	
A 26	THE CLAIM WAS OVERPAID DUE TO A MISCELLANEOUS OR UNDETERMINED CAUSE.	94	MA 67
A 42	THE MEDICARE CROSSOVER CLAIM WAS OVERPAID DUE TO A MISCELLANEOUS REASON.	95	MA 67
A 22	THE CLAIM WAS UNDERPAID DUE TO A MISCELLANEOUS CAUSE.	95	MA 67

ODJFS ADJUSTMENT CODE OR LEGACY EOB CODE	"DRAFT" OHIO ADJUSTMENT OR LEGACY EOB CODE DESCRIPTION	HIPAA ADJUSTMENT REASON CODE OR (PLB SEGMENT CODE *)	HIPAA REMITTANCE ADVICE REMARK CODES
A 41	THE MEDICARE CROSSOVER CLAIM WAS UNDERPAID DUE TO A MISCELLANEOUS REASON.	95	MA 67
A 18	THE ADJUSTMENT IS DUE TO AN AUDIT/COST SETTLEMENT BY THE BUREAU OF HOSPITAL RATES AND AUDITS.	95	
A 21	THE CLAIM HAS BEEN REVIEWED BY THE PEER REVIEW ORGANIZATION AND ADJUSTED ACCORDINGLY.	95	N 10
A 23	THE CLAIM WAS PAID AT THE INCORRECT RATE.	95	MA 67
680	THE SERVICE BILLED REQUIRES CLIA CERTIFICATION. THE DEPARTMENT SHOWS NO CLIA INFORMATION ON FILE FOR YOUR PROVIDER NUMBER. TO RECEIVE PAYMENT YOU MUST REGISTER YOUR CLIA # AND CERTIFICATE TYPE. PLEASE SEE REMITTANCE ADVICE NEWSLETTER NOTICES DATED: NOV. 11, 18, 25 AND DEC. 2, 9, & 16, 1998.	95	MA 129
681	THE CLIA # ON FILE WITH ODHS CONTAINS A CERTIFICATE TYPE OF WAIVER OR MICROSCOPY AND THE SERVICE BILLED IS NOT PERMITTED FOR THIS CERTIFICATE TYPE. TO RECEIVE PAYMENT FOR THIS SERVICE A CERTIFICATE TYPE OF REGISTRATION, CERTIFICATE OR ACCREDITATION IS REQUIRED.	95	MA 129
727	RECIPIENT IS ENROLLED IN THE GENERAL ASSISTANCE (GA) OR DISABILITY ASSISTANCE (DA) AND THE CLAIM SUBMITTED IS NOT VALID GA/DA CLAIM TYPES. VALID CLAIM TYPES ARE: MEDICAL SUPPLIER, DENTAL, INDEPENDENT LAB, PHYSICIAN, CLINIC AND PHARMACY.	96	
322	THE PROCEDURE AND/OR REVENUE CODE BILLED IS NOT COVERED BY THE MEDICAID PROGRAM FOR THE DATE OF SERVICE BILLED. REVIEW THE PROCEDURE AND/OR REVENUE CODE AND SERVICE DATE ON THE CLAIM FOR ACCURACY.	96	M 67 M 50
561	NONSPECIFIC PROCEDURE - PROCEDURE CODE #2 (CLINICAL EDITOR).	96	
361	THE PROCEDURE AND/OR REVENUE CODE BILLED IS NOT IN THE DEPARTMENT'S REFERENCE FILE. REVIEW THE PROCEDURE AND/OR REVENUE CODE ON THE CLAIM FOR ACCURACY.	96	M 67
360	THE NDC HAS NO CORRESPONDING RECORD ON THE PDD FILE.	96	N 60
470	INPATIENT MENTAL HOSPITAL CLAIM FOR A RECIPIENT AGE 21-64 IS NOT A MEDICAID COVERED SERVICE.	96	
562	NONSPECIFIC PROCEDURE - PROCEDURE CODE #3 (CLINICAL EDITOR).	96	M 51
484	RECIPIENT RESTRICTED BY EXPEDITED ELIGIBILITY. INPATIENT HOSPITAL SERVICES ARE NON-COVERED SERVICES UNDER THE EXPEDITED MEDICAID PROGRAM.	96	
389	THE DESI DRUG INDICATOR IS EQUAL TO "DESI" 91). DRUG IS NOT COVERED BY MEDICAID PROGRAM.	96	

ODJFS ADJUSTMENT CODE OR LEGACY EOB CODE	"DRAFT" OHIO ADJUSTMENT OR LEGACY EOB CODE DESCRIPTION	HIPAA ADJUSTMENT REASON CODE OR (PLB SEGMENT CODE *)	HIPAA REMITTANCE ADVICE REMARK CODES
107	THE AMOUNT MEDICARE APPROVED FOR THE SERVICE WAS GREATER THAN THE TOTAL CLAIM CHARGE.	96	N 18
563	NONCOVERED PROCEDURE - PROCEDURE CODE #2 (CLINICAL EDITOR).	96	M 51
824	COMPLETION OF THE SERVICE IS TOO UNTIMELY FROM THE INITIATION OF THE SERVICE OR REQUEST.	96	
390	DRUG NOT ALLOWED FOR NURSING HOME RECIPIENT.	96	
718	NDC IS NOT COVERED FOR THE DATE OF SERVICE BILLED.	96	
726	THE RECIPIENT IS ENROLLED IN THE GENERAL ASSISTANCE PROGRAM AND THE DRUG DISPENSED IS A SCHEDULE '2' DRUG. SCHEDULE '2' DRUGS ARE NOT COVERED UNDER THE GENERAL ASSISTANCE PROGRAM.	96	
330	THE PROCEDURE CODE BILLED IS NOT COVERED BY THE OHIO MEDICAID PROGRAM OR THE SERVICE BILLED IS RESTRICTED TO TITLE XIX RECIPIENTS AND THE RECIPIENT IS A DA (DISABILITY ASSISTANCE) OR GA (GENERAL ASSISTANCE) RECIPIENT. SEE MEDICAID HANDBOOK AND MEDICAL CARD FOR COVERAGE LIMITATIONS.	96	
977	POSTPARTUM VISIT 59430 CANNOT BE BILLED WITH DELIVERY CODES INCLUDING POSTPARTUM CARE CODES (59410, 59515, 59614, 59622). WHEN THE DELIVERY IS DENIED WITH EOB 977, SUBMIT AN ADJUSTMENT TO CREDIT THE POSTPARTUM VISIT PAYMENT, THEN RESUBMIT THE CLAIM FOR THE	97	
50	APNEA MONITOR/T.N.S. UNIT SUPPLIES WERE DISPENSED WITHIN THE MONTH AS THE RENTAL OF THE UNIT.	97	
A 05	THE CLAIM IS AN INTERIM PAYMENT. THE FINAL BILL (ADMIT THROUGH DISCHARGE) HAS BEEN SUBMITTED TO BE PAID.	101	
929	THE CLAIM IS A PHARMACY CLAIM WHOSE SERVICE DATE IS ON OR AFTER 02/01/2000 AND WHOSE INPUT MEDIA IS 0, 1 OR 2 INDICATING A CLAIM SUBMITTED DIRECTLY TO ODHS. SUCH CLAIMS ARE TO BE SUBMITTED TO FIRST HEALTH SERVICE CORPORATION, THE ODJFS PHARMACY POST CONTRACTOR.	404	
248	PROCEDURE CODE X5500 MUST BE BILLED WITH ANOTHER AT-RISK SERVICE. (HOME VISIT TRAVEL)	107	
188	FOR OUTPATIENT HEALTH FACILITIES AND RURAL HEALTH FACILITIES AN ENCOUNTER CODE WAS ENTERED, BUT NO PROCEDURE CODE WAS ENTERED ON THE PROCEEDING LINE. REVIEW YOUR BILLING INSTRUCTIONS FOR PROPER COMPLETION OF THIS INVOICE.	107	M 20

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987	FOR IN-STATE OUTPATIENT CLAIMS; PROCEDURE CODE 99402, 99403 OR 99404 IS BILLED AND NO LINE ITEM FOR THE SAME DATE OF SERVICE CONTAINING PROCEDURE CODE 99381-99385, OR 99391-99395 (HEALTHCHEK PROCEDURE CODES) IS PRESENT IN THE CLAIM. SERVICES ARE NOT PAYABLE WITHOUT A HEALTHCHEK EXAM.	107	
103	LINE ITEM CONTAINS ERROR(S), HOWEVER CLAIM DENIED FOR ANOTHER	107	
289	TAPE SUBMITTER NOT AUTHORIZED TO SUBMIT CLAIMS FOR THIS PROVIDER. ALL PROVIDERS UTILIZING DIRECT ENTRY BILLING INTERMEDIARIES MUST REGISTER SUCH AGENTS WITH PROVIDER ENROLLMENT BY REQUESTING THAT THE INTERMEDIARY'S PROVIDER NUMBER BE ADDED TO THEIR PROVIDER MASTER RECORD.	109	N 51
938	DOS PRIOR TO CONTRACT DATE (NCPDP EDIT 67, FIRST HEALTH POS EDIT 021).	409	
146	THE DATE PRESCRIBED ENTERED IN BLOCK 18 IS AFTER THE DATE DISPENSED IN BLOCK 21. REVIEW BOTH DATES ENTERED IN BLOCKS 18 AND 21 FOR ACCURACY.	440	
127	THE DATE OF SERVICE ENTERED ON THE CLAIM IS GREATER THAN THE DATE THE DEPARTMENT RECEIVED THE CLAIM AS INDICATED BY THE TRANSACTION CONTROL NUMBER (TCN) ON THE REMITTANCE ADVICE.	110	M 52
871	OCCURRENCE CODES 43 OR 57 (CANCELED SURGERY) IS PRESENT IN THE CLAIM RECORD AND THE REQUIRED CANCELED PROCEDURE CODE IS MISSING. REBILL WITH PROCEDURE CODE X7200 (CANCELED SURGERY W/O ANESTHESIA) OR X7200 (CANCELED SURGERY WITH ANESTHESIA) WITH APPROPRIATE REVENUE CODE.	115	
57	DENTAL EXAM LIMIT 1 PER 180 DAYS.	119	M 86
53	PACT MANAGEMENT FEE LIMITED TO 1 PER MONTH.	119	M 86
12	SERVICE IS LIMITED TO 300 UNITS PER MONTH.	119	M 86
106	UB82 - EXCEEDS OUTPATIENT VISIT LIMIT.	119	M 86
84	SERVICE IS LIMITED TO 1 UNIT EVERY 5 YEARS.	119	M 86
2	SERVICE LIMITED TO 1 PER 365 DAYS.	119	M 90
93	SERVICE IS LIMITED TO 1 UNIT EVERY 2 MONTHS.	119	M 86
72	SERVICE IS LIMITED TO 1 UNIT EVERY 120 DAYS.	119	M 86
51	CHIRO LIMIT IS 4 PER MONTH.	119	M 86
3	SERVICE IS LIMITED TO 1 UNIT EVERY 2 YEARS.	119	M 86
664	LINE ITEM QUANTITY IS GREATER THAN 9 UNITS. A MAXIMUM OF 9 UNITS PER REVENUE PER DATE OF SERVICE ARE PERMITTED. RESUBMIT CLAIM REDUCING UNITS AND APPLICABLE CHARGE TO THE MAXIMUM LIMIT.	119	
15	SERVICE LIMITED TO 4 PER MONTH.	119	M 86

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17	48 PHYSICAL MEDICINE MODALITIES PER YEAR.	119	
32	SERVICE IS LIMITED TO 1 UNIT EVERY 8 YEARS.	119	M 86
48	SERVICE IS LIMITED TO 1 UNIT PER MONTH.	119	M 86
593	RECIPIENT HAS EXCEEDED THE WEEKLY 14 HOUR (56 UNITS) ALLOWANCE FOR PROCEDURE CODES Z8001 AND Z8002.	119	N 30
594	RECIPIENT HAS EXCEEDED THE MONTHLY 56 HOURS (224 UNITS) ALLOWANCE FOR PROCEDURE CODES Z8001 AND Z8002.	119	N 30
982	SERVICE LIMITED TO 1 UNIT OF SERVICE EVERY 6 YEARS.	119	
1	SERVICE LIMITED TO 1 PER 180 DAYS.	119	M 86
595	RECIPIENT HAS REACHED OR EXCEEDED 75% OF THEIR MONTHLY COST CAP ALLOWANCE. ACCUMULATED MEDICAL ALLOWED CHARGES FOR THE CALENDAR MONTH IS GREATER THAN OR EQUAL TO: E, K, P, U - \$2,250.00; F, L, Q, V, 7 - \$4,500.00; G, M, R, W - \$6,750.00; I, N, S, X, 8 - \$9,000.00; J, O, T, Y - \$11,025.00.	119	N 30
499	QUANTITY EXCEEDS THE MEDICAID ALLOWABLE UNITS OF SERVICE THAT CAN BE RENDERED TO A RECIPIENT IN 1 DAY.	119	
596	RECIPIENT HAS REACHED OR EXCEEDED 100% OF THEIR MONTHLY COST CAP ALLOWANCE. ACCUMULATED MEDICAID ALLOWED CHARGES FOR THE CALENDAR MONTH IS GREATER THAN OR EQUAL TO: E, K, P, U - \$3,000; F, L, Q, V, 7 - \$6,000; G, M, R, W - \$9,000; I, N, S, X, 8 - \$12,000; J, O, T, Y - \$14,700.	119	
11	SERVICE LIMITED TO 1 EVERY 4 YEARS.	119	M 86
472	MAXIMUM UNITS EXCEEDED; LIMIT IS 9 UNITS PER OUTPATIENT LINE ITEM DATE OF SERVICE.	119	
4	SERVICE IS LIMITED TO 1 EVERY 3 YEARS.	119	M 86
973	SERVICE LIMITED TO 10 UNITS EVERY 8 YEARS.	119	
949	DAYS SUPPLY EXCEED MAXIMUM (NCPDP EDIT 76, FIRST HEALTH POS EDIT	449	
974	SERVICE IS LIMITED TO 20 UNITS PER MONTH PER STOMA.	119	
119	FOR OUTPATIENT CLAIMS, OVER 4 VISITS PER CALENDAR MONTH FOR REVENUE CODE 47X.	119	M 86
113	FOR UB82 OR UB92 THE ADMISSION DATE ENTERED ON THE INVOICE DOES NOT MATCH THE FROM DATE ENTERED ON THE INVOICE. CHECK INFORMATION ENTERED FOR ACCURACY.	125	MA 40
112	FOR UB82 OR UB92 THE LINE ITEM SERVICE DATE ENTERED ON THE INVOICE IS OUTSIDE OF THE STATEMENT COVERS PERIOD. CHECK FOR ACCURACY.	125	MA 06 MA 31

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881	FOR OP CLAIMS AFTER 06/30/88 BUT PRIOR TO 10/01/88, THE PRIMARY DIAGNOSIS CODE IS V64.1 - V64.3 AND OCCURRENCE CODE 57 (CANCELED SURGERY IS MISSING). FOR SERVICES ON OR AFTER 10/01/88, THE PRIMARY DIAGNOSIS CODE IS V64.1 - V64.3 AND OCCURRENCE CODE 43 IS MISSING).	125	
115	FOR UB82 OR UB92 BILLED WITH REVENUE CODES 100-179, 200-230 OR 720-729 THE NUMBER OF TOTAL UNITS ENTERED IN THE UNITS COLUMN DOES NOT EQUAL THE NUMBER OF DAYS ENTERED IN THE COVERED DAYS BLOCK OF THE INVOICE.	125	M 53
346	INDEPENDENT LAB MAY NOT BILL PROFESSIONAL COMPONENT SEPARATELY. MODIFIER 26 IS INVALID FOR THIS CATEGORY-OF-SERVICE.	125	M 78
295	PATIENT STATUS 30 (STILL PATIENT) IS NOT ALLOWED FOR BILL TYPES 111, 114, 121 OR 124. (EXPLANATION - CAN'T STILL BE A PATIENT. THESE TYPES MUST BE INTERIM BILLS).	125	MA 43
204	FOR UB82 OR UB92 THE ATTENDING PHYSICIAN MEDICAID PROVIDER NUMBER ENTERED IN THE ATTENDING PHYSICIAN I.D. BLOCK IS INVALID. REVIEW INFORMATION ENTERED FOR ACCURACY.	125	MA 68
899	CLAIM HAS MORE THAN 25 ERRORS. TAPE PROVIDERS MUST RESUBMIT HARDCOPY.	125	
400	TYPE BILL 135 (LATE CHARGES) CONTAINS A REVENUE CODE OTHER THAN 30X, 31X, 32X, 33X, 34X, 35X, 45X, 51X AND/OR A LINE ITEM PROCEDURE CODE IS NOT A VALID LAB, RADIOLOGY, ARPS, CLINIC OR ER VISIT CODE. PHARMACY, MEDICAL SUPPLIES, SURGERY AND OTHER VISIT SERVICES ARE NOT	125	MA 30
A O6	THE PROVIDER BILLED A REVENUE CENTER CODE IN ERROR OR ERRONEOUSLY OMITTED IT IN THE ORIGINAL SUBMISSION.	125	M 50
A 86	LTCF FINAL SETTLEMENT T PAYMENT.	125	N 10
637	EFFECTIVE JAN 1, 95 (DATE OF RECEIPT) ODHS NO LONGER ACCEPTS HARD-COPY 6780 CLAIMS SUBMITTED FOR DME, VISION CARE, LAB, PHYSICIAN,AND CLINIC SERVICES. ALSO EFFECTIVE JAN 1, 95 (DATE OF RECEIPT) ODHS NO LONGER ACCEPTS HARDCOPY UB82 CLAIMS FOR HOME HEALTH, INPATIENT/OUTPATIENT HOSPITAL AND INPATIENT/OUTPATIENT X-OVER SERVICES.	125	N 34
A 14	THE PROVIDER HAS EITHER OMITTED INFORMATION OR BILLED THE INCORRECT CODE/MODIFIER/UNITS/MINUTES, ETC.	125	
A 15	MEDICAID PAYMENT WAS MADE TO THE WRONG PROVIDER.	125	
197	PATIENT STATUS CODE IS INVALID FOR AN INPATIENT CLAIM WITH THE SAME BEGIN AND END DATE.	125	MA 31 MA 43

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118	BASE RATE OR MULTIPLE PASSENGER PROCEDURE CODE (A0010, A0220, A0070, A0130, A0150, Z0030) WAS ENTERED IN COLUMN B AND THE CORRESPONDING UNITS OF SERVICE ENTERED IN COLUMN E WAS GREATER	125	M 53
660	THE CATEGORY OF SERVICE IN THE CLAIM RECORD IS '86'; NURSING HOME THERAPIES AND VALUE CODE 50, 51 OR 52 IS MISSING. ONE OF THESE VALUES ALONG WITH THE # OF THERAPY DAYS (VALUE CODE AMOUNT) MUST BE PRESENT ON ALL NURSING HOME THERAPY CLAIMS.	125	M 49
659	THE CATEGORY OF SERVICE IN THE CLAIM RECORD IS '86'; NURSING HOME THERAPIES AND THE PATIENT STATUS CODE WAS MISSING OR INVALID. FIELD IS REQUIRED TO RECEIVE PAYMENT. VALID VALUES FOR NURSING HOME THERAPY CLAIMS ARE 01, 20 AND 30.	125	MA 43
193	IF THE TYPE OF BILL EQUALS 115, COVERED DAYS MUST EQUAL 0.	125	MA 30 MA 32
661	THE CATEGORY OF SERVICE IN THE CLAIM RECORD IS '86'; NURSING HOME THERAPIES, THE VALUE CODE IS 50, 51 OR 52 AND THE NUMBER OF THERAPY DAYS (VALUE CODE AMOUNT) ASSOCIATED WITH THIS CODE IS EQUAL TO	125	M 49
167	THE PATIENT STATUS BILLED ON THE UB INVOICE IS INCORRECT. FOR THE UB82, VALID VALUES ARE 01-04, 06, 07, 20, 30. FOR THE UB92, THE VALID VALUES ARE 01-04, 06, 07, 10, 20, 30. REFER TO THE MEDICAID HOSPITAL HANDBOOK FOR PROPER BILLING INSTRUCTIONS.	125	MA 43
459	BIRTH WEIGHT CONDITION CODE MISSING. A CONDITION CODE IN THE RANGE 88-96 MUST BE PRESENT FOR CLAIMS GROUPING INTO ANY ONE OF THE FOLLOWING DRGS. FOR DISCHARGE DATES PRIOR TO 01/01/97; DRG 387. FOR DISCHARGES AFTER 12/31/96; DRG 385, 388 - 391 OR 892 - 898.	125	M 44
440	INVALID 4TH OR 5TH DIGIT FOR DIAGNOSIS CODE #1 (CLINICAL EDITOR).	125	MA 63
441	UNACCEPTABLE PRINCIPLE DIAGNOSIS. (CLINICAL EDITOR).	125	MA 63
A 30	THE CLAIM IS BEING REPROCESSED TO THE PROVIDER. A PREVIOUS WARRANT WAS EITHER CANCELLED OR VOIDED.	125	MA 74
A 31	THE WARRANT FOR THIS CLAIM WAS RETURNED AND CANCELLED.	125	MA 74
663	A LINE ITEM SERVICE WAS DENIED ON A NURSING HOME THERAPY CLAIM, CORRECTIVE ACTION IS REQUIRED BEFORE THE CLAIM CAN BE CONSIDERED FOR PAYMENT. REVIEW CLAIM FOR SPECIFIC CLAIM SUBMISSION ERRORS COMMITTED.	125	
A 32	THE WARRANT FOR THIS CLAIM WAS RETURNED AND VOIDED.	125	MA 74
A 33	THE CLAIM WAS FORCED PAID IN ERROR AND SHOULD HAVE BEEN DENIED.	125	MA 67

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135	FOR UB82 OR UB92 THE ADMISSION TYPE ENTERED IN THE TYPE OF ADMISSION BLOCK IS INCORRECT. VALID VALUES ARE 1 THROUGH 8. REFER TO THE MEDICAID HOSPITAL HANDBOOK FOR ACCURATE BILLING	125	MA 41
538	INVALID DIAGNOSIS CODE-DIAGNOSIS CODE #5 (CLINICAL EDITOR).	125	M 64
537	INVALID DIAGNOSIS CODE-DIAGNOSIS CODE #4 (CLINICAL EDITOR).	125	M 64
177	FOR UB82 OR UB92 ADMISSION TYPE "4" NEWBORN IS BILLED AND THE ADMISSION SOURCE INDICATED ON THE INVOICE IS NOT A 1, 2, 3, OR 4. REFER TO THE MEDICAID HOSPITAL HANDBOOK FOR BILLING INSTRUCTIONS.	125	MA 41 MA 42
536	INVALID DIAGNOSIS CODE-DIAGNOSIS CODE #3 (CLINICAL EDITOR).	125	M 64
461	REVENUE CODE BILLED IS NOT COVERED FOR CLAIM DATES OF SERVICE.	125	M 50
462	FOR UB82 OR UB92 ONE OR MORE OF THE ICD9 PROCEDURE CODES THAT WERE ENTERED IN THE PROCEDURE CODE BLOCKS ARE NOT LISTED ON THE DEPT'S PROCEDURE CODE REFERENCE FILE. REFER TO THE ICD9-CM BOOK AND THE MEDICAID HOSPITAL HANDBOOK FOR PROPER CODING.	125	MA 66
463	REVENUE CODE IS NOT ALLOWED.	125	M 50
138	FOR UB82 OR UB92 VALID TYPE OF BILL VALUES FOR OHIO MEDICAID ARE 110-119, 121-128, 131, 135-138, 211-215, 221-229, 235, 251-255, 261-265, 331-335, 337, 338, 341-347, 621-625, 711-715, 721-729, 731-735, 741-745.	125	MA 30
175	FOR UB82 OR UB92 THE SURGERY DATE ENTERED IN THE PROCEDURE DATE BLOCK IS OUTSIDE THE STATEMENT COVERS PERIOD AS INDICATED ON THE BILLED INVOICE. REVIEW THE INFORMATION ENTERED IN THESE BLOCKS FOR ACCURACY.	125	M 67
635	TYPE BILLS 114 AND 124 NOT VALID FOR DRG HOSPITALS. VALID FOR DRG-EXEMPT AND MENTAL HOSPITALS.	125	MA 30
A 58	A MEDICARE CROSSOVER CLAIM IS BEING REPROCESSED FOR THIS PROVIDER. A PREVIOUS WARRANT WAS CANCELLED OR VOIDED.	125	MA 74
133	THE TOTAL CLAIM CHARGE BILLED DOES NOT EQUAL THE SUM OF THE INDIVIDUAL LINE ITEM CHARGES BILLED ON THE CLAIM. REVIEW THE ADDITION OF LINE ITEM CHARGES FOR ACCURACY. IF THERE WAS A KEYING OR SCANNER READ ERROR, SUBMIT A NEW CLAIM.	125	M 54
331	TAPE PROVIDERS MUST SUBMIT HARDCOPY CLAIM. CLAIM REQUIRES MANUAL REVIEW OR MANUAL PRICING.	133	
273	INTERIM BILL CONFLICTS WITH A PREVIOUSLY PAID ADMIT-THRU- DISCHARGE CLAIM TYPE BILL 111 OR 121.	135	N 47 N 74
385	BILL TYPE IS 112, 113, 122 OR 123 (INTERIM BILLS) AND PATIENT STATUS IS NOT 30 (STILL PATIENT).	135	MA 43

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386	BILL TYPE IS 112, 113, 122 OR 123, PATIENT STATUS IS 30 (STILL PATIENT) AND COVERED DAYS IS LESS THAN 60 DAYS. FOR DATES OF DISCHARGE ON OR AFTER 09/03/91; THE NUMBER OF COVERED DAYS IS LESS THAN 60 DAYS. FOR DATES OF DISCHARGE ON OR AFTER 09/03/91; THE NUMBER OF COVERED DAYS IS LESS THAN 30 DAYS.	135	
A 61	RETROACTIVE ELIGIBILITY FOR MEDICARE PART A HAS BEEN DISCOVERED FOR THIS PATIENT AND CLAIM SERVICE DATES.	136	
A 62	RETROACTIVE ELIGIBILITY FOR MEDICARE PART B HAS BEEN DISCOVERED FOR THIS PATIENT AND CLAIM SERVICE DATES.	136	
130	THE RECIPIENT NUMBER ENTERED ON THE CLAIM MAY HAVE AN INCORRECT DIGIT, MISSING DIGITS OR CONTAIN ZEROES. FOR THE CORRECT 12-DIGIT RECIPIENT NUMBER, REFER TO THE PATIENT'S MEDICAL CARD WHICH CORRESPONDS TO THE SERVICE DATE BILLED.	140	MA 61
202	THE LAST TWO DIGITS OF THE TWELVE DIGIT BILLING NUMBER IS MISSING ON THE INVOICE. CHECK THE MEDICAL CARD FOR ACCURATE ELIGIBILITY INFORMATION.	140	MA 61
730	ON THE FIRST DATE OF SERVICE THE RECIPIENT IS ELIGIBLE FOR GENERAL ASSISTANCE (GA) OR DISABILITY ASSISTANCE (DA) AND ELIGIBLE FOR MEDICAID ON THE LAST DATE OF SERVICE OR VICE VERSA. CLAIM CAN NOT BE PRICED WHEN THIS CONDITION EXISTS. RESUBMIT GA/DA SERVICE DATES ON A SEPARATE CLAIM FORM.	141	
A 10	THE PATIENT HAS EITHER PARTIAL OR TOTAL MEDICAID INELIGIBILITY FOR THE CLAIM DATES OF SERVICE.	141	
662	ODHS RECORDS INDICATE THAT THE RECIPIENT DID NOT RESIDE IN A LTC FACILITY OR DID NOT RESIDE IN THE FACILITY FOR THE ENTIRE DATE SPAN INDICATED ON THE CLAIM (BLOCK 22 OF UB82 CLAIM FORM). FILE CLAIM(S) USING SERVICE DATES INVOLVING CONTINUOUS LTC RESIDENCY ONLY.	141	
267	LONG-TERM CARE CLAIM DATES OF SERVICE DO NOT AGREE WITH NURSING HOME DATE SPAN IN RECIPIENT FILE.	141	
244	THE RECIPIENT'S BILLING NUMBER ENTERED ON THE INVOICE IS MEDICAID ELIGIBLE, BUT MEDICAID COVERAGE DOESN'T EXIST FOR THE DATE(S) OF SERVICE AS NOTED ON THE INVOICE. REVIEW THE MEDICAL CARD BILLING NUMBER COLUMN AND ELIGIBLE BEGIN DATE AND VOID AFTER DATE FOR VALID INFORMATION.	141	
235	PARTIAL RECIPIENT ELIGIBILITY EXISTS. RESUBMIT CLAIM HARDCOPY WITH A COPY OF MEDICARE EOMB.	141	MA 04 N4

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A 72	LTCF RECOUPMENT OF PATIENT RESOURCES/LIABILITY APPLIED TOWARDS COST OF CARE.	142	
A 81	LTCF PROVIDER HAS BEEN UNDERPAID DUE TO DECREASE IN PATIENT RESOURCES/LIABILITY.	142	
A 74	LTCF RECOUPMENT OF LUMP SUM APPLIED TOWARDS COST OF CARE.	142	
A 12	THE PATIENT IS RESPONSIBLE FOR THE MONTHLY SPENDDOWN AMOUNT OR HAS PAID A PORTION OF THE BILL.	142	
A 73	LTCF RECOUPMENTS OF ADDITIONAL PATIENT RESOURCES/LIABILITY DUE TO MONTHLY INCREASE.	142	
867	PATIENT STATUS CODE "05" IS RESTRICTED TO HOSPITALS WITH DISTINCT PART B PSYCHIATRIC UNITS ONLY.	150	MA 43
953	LIMIT - NO MORE THAN 3 RESTORATIONS PER TOOTH SHALL BE REIMBURSED REGARDLESS OF THE NUMBER OF SURFACES RESTORED.	150	
477	PROCEDURE CODE IS EQUAL TO 90000-90654 AND THE BILLED QUANTITY IS GREATER THAN (1) ONE.	151	M 63
13	SERVICE LIMITED TO 1 PER PATIENT/PROVIDER.	151	
318	PROCEDURE CODE EQUALS 10000-69999, MODIFIER DOES NOT EQUAL AA, AB, AC OR AE AND THE UNITS OF SERVICE BILLED IS GREATER THAN 1. ONLY CLAIMS FOR ANESTHESIA MINUTES; PROCEDURE CODES MODIFIED BY AA, AB, AC OR AE CAN BE SUBMITTED WITH QUANTITIES GREATER THAN 1.	151	M 53 M 78
321	SUBMITTED QUANTITY EXCEEDS ALLOWED MAXIMUM. UNITS HAVE BEEN REDUCED.	151	N 14
10	2 RESTORATION LIMIT PER ANTERIOR TOOTH.	151	
14	MUTUALLY EXCLUSIVE EXAMS.	151	
7	RESTORATIONS LIMITED TO A MAXIMUM OF 3 PINS.	151	
677	PAYMENT OF MATERNITY BIRTH PAYMENT CLAIMS ARE LIMITED TO 1 UNIT OF SERVICE PER RECIPIENT PER PROVIDER EVERY 90 DAYS.	151	
98	MAXIMUM NUMBER OF REFILLS FOR THIS DRUG HAS BEEN EXCEEDED.	151	
863	OUTPATIENT CLAIM SERVICE DATES CAN NOT OVERLAP 07/01/89 BEGIN DATE FOR NEW OUTPATIENT PRICING METHODOLOGY.	152	
338	DRUG QUANTITY IS LESS THAN DRUG MINIMUM SUPPLY ON PDD FILE.	153	
152	DRUG CODE ON BILL IS MISSING OR INVALID.	-	M-119
151	THE PRESCRIBING PROVIDER NUMBER IS MISSING OR INVALID.	-	
469	REQ LA/PA, MD CALL 877-518-1546 (NCPDP EDIT 75, FIRST HEALTH POS EDIT	-	
153	THE DRUG CODE IS NOT NUMERIC.	-	M-119

ODJFS ADJUSTMENT CODE OR LEGACY EOB CODE	"DRAFT" OHIO ADJUSTMENT OR LEGACY EOB CODE DESCRIPTION	HIPAA ADJUSTMENT REASON CODE OR (PLB SEGMENT CODE *)	HIPAA REMITTANCE ADVICE REMARK CODES
155	THE DRUG QUANTITY IS ENTERED AS A ZERO AMOUNT OR IS MISSING FROM BLOCK 22 OF THE 6746 INVOICE. REVIEW FOR ACCURACY AND REFER TO THE PHARMACY BILLING INSTRUCTIONS FOR PROPER COMPLETION OF THIS INVOICE.	-	
150	DATE PRESCRIBED TO DATE DISPENSED EXCEEDS LIMIT.	-	
154	THE PRESCRIPTION NUMBER IS MISSING FROM BLOCK 20. A MAXIMUM OF SIX DIGITS CAN BE ENTERED IN THIS BLOCK. REFER TO PHARMACY BILLING INSTRUCTIONS FOR PROPER COMPLETION OF THIS INVOICE.	-	
144	THE PRESCRIBED DATE IS MISSING FROM BLOCK 18 OF THE 6746 INVOICE. FOR PROPER BILLING, REFER TO YOUR PHARMACY BILLING INSTRUCTIONS.	16,125	
147	FOR UB82 OR UB92 AN ACCOMMODATION REVENUE CODE TO IDENTIFY ROOM AND BOARD CHARGE WAS BILLED AND THE CORRESPONDING ROOM RATE IS MISSING FROM THE INVOICE. REFER TO THE MEDICAID PROVIDER HOSPITAL HANDBOOK FOR BILLING INSTRUCTIONS.	17,125	M 79
411	PROVIDER EXCEPTION INDICATOR = 20; FULL REVIEW 1.	A 1	N10
483	REVENUE CODE IS NOT ON FILE OR NOT ALLOWED. COVERED CHARGE MOVED TO NON-COVERED CHARGE FIELD.	A 1	M 50
381	THERE IS NO RATE ON THE PROVIDER MASTER FILE FOR THE SERVICE DATE BILLED.	A 1	
108	CRITICAL CARE SERVICES (99291-92) WITH OTHER SERVICES PERFORMED DURING CRITICAL CARE.	A 1	M 80
378	THERE IS NO PRICE IN THE PROVIDER CHARGE FILE FOR THE SERVICE DATE BILLED.	A 1	
460	THE REVENUE CODE BILLED IS NOT ON FILE.	A 1	M 50
377	CANNOT BILL REVENUE CODES 170 TO 175, 179, 230 AND 231 IF RECIPIENT'S AGE IS GREATER THAN TWO.	A 1	M 50
482	CONDITION CODE 83 IS VALID ONLY FOR HOME HEALTH CLAIMS. INVALID FOR INPATIENT/OUTPATIENT UB 82.	A 1	M 44
882	FOR OUTPATIENT CLAIM AFTER 6/30/88, OCCURRENCE CODE 57 MUST HAVE A DATE.	A 1	M 45
393	AN INVALID TOOTH NUMBER WAS ENTERED IN COLUMN "F" OF THE 6780 INVOICE. VALID TOOTH NUMBERS ARE: (01-32) OR (A-T). REVIEW THE TOOTH NUMBER ENTERED ON THE CLAIM FORM FOR ACCURACY.	A 1	N 37
485	CLAIM RECORD CONTAINS A REVENUE CODE THAT IS NOT ON FILE OR NOT ALLOWED, DRG EXEMPT HOSPITAL ONLY.	A 1	M 50
521	SERVICE CONFLICT. PROVIDER CANNOT ACT AS BOTH PRIMARY AND ASSISTANT SURGEON (MODIFIER 80).	A 1	MA 102

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682	THE SERVICE BILLED REQUIRES CLIA CERTIFICATION AND THE DATE OF SERVICE OF THIS PROCEDURE DOES NOT FALL WITHIN THE CERTIFICATION DATE SPANS OF ANY CLIA CERTIFICATE ON FILE FOR THIS PROVIDER.	A 1	MA 51
619	FOR HMO BIRTH PAYMENT CLAIMS; THE RECIPIENT'S COUNTY OF RESIDENCE DOES NOT MATCH THE HMO PROVIDER'S COUNTY LOCATION.	A 1	
887	FOR OUTPATIENT CLAIMS AFTER 06/30/88, LINE ITEM SERVICE DATE MUST BE > 1ST SERVICE DATE ON CLAIM.	A 1	MA 06
294	PROVIDER EXCEPTION INDICATOR IS 21 - PROCEDURE CODE REVIEW.	A 1	N 10 N 35
432	THIS IS A GROUPER EDIT. THE INFORMATION ENTERED ON THE CLAIM (I.E. DIAGNOSIS, PROCEDURE) HAS CAUSED THE ASSIGNMENT OR DRG 470 WHICH IS UNGROUPABLE. REVIEW DIAGNOSIS CODES, PROCEDURE CODE AND RECIPIENT NUMBER ENTERED OF THE CLAIM FOR ACCURACY.	A 8	
431	DRG 469 INVALID FOR DISCHARGE (GROUPER).	A 8	
A O4	CLAIM IS PAID THROUGH ADJUSTMENT SECTION BECAUSE AN UNGROUPABLE ORGAN TRANSPLANT SERVICE WAS PERFORMED.	A 8	
137	FOR UB82 OR UB92 THE CALCULATED TOTAL CHARGE FOR THE NONCOVERED LINE ITEM CHARGES DOES NOT EQUAL THE TOTAL NONCOVERED CHARGE AS INDICATED ON THE BILLED INVOICE. CHECK THE ADDITION FOR THE NONCOVERED LINE ITEM AMOUNTS SUBMITTED.	A1	MA 130
171	NONCOVERED LINE ITEM CHARGE IS GREATER THAN THE BILLED LINE ITEM CHARGE.	A1	M 54
920	THE RECIPIENT'S WAIVER PROGRAM INDICATOR IS EQUAL TO A-D, 1, 2, 4 OR 5 AND A LINE ITEM BILLED IS EQUAL TO Z8000, Z8501 OR Z9000. THE RECIPIENT IS ENROLLED IN THE PASSPORT WAIVER PROGRAM AND IS NOT ELIGIBLE TO RECEIVE THESE SERVICES.	B 1	N 30
921	OUTPATIENT CLAIM CONFLICTS WITH PAID INPATIENT CLAIM WITH THE SAME OR OVERLAPPING SERVICE DATES.	B 13	
A O2	THE PAID CLAIM HAS OVERLAPPING SERVICE DATES WITH ANOTHER PAID CLAIM.	B 13	
224	POSSIBLE CONFLICT, CROSSOVER, DIFFERENT CLAIM TYPES.	B 13	
236	PATIENT WAS READMITTED WITHIN ONE DAY OF ANOTHER PAID INPATIENT STAY. REFER TO THE HOSPITAL HANDBOOK FOR PROPER BILLING INSTRUCTIONS.	B 13	N 47

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924	MUTUALLY EXCLUSIVE OXYGEN SERVICES. A CONFLICT EXISTS BETWEEN TWO OR MORE LINE ITEMS WITH THE SAME DATE OF SERVICE IN WHICH TWO DIFFERENT OXYGEN CODES POSSESSING THE SAME DESCRIPTION WERE BILLED. CONFLICTING COMBINATIONS INCLUDE Q0038/E0441, Q0039/E0442, Q0042/E0424 AND Q0043/E0439.	B 13	
223	POSSIBLE DUPLICATE, CROSSOVER, DIFFERENT CLAIM TYPES.	B 13	
104	VISIT BILLED WITHIN FOLLOW-UP PERIOD OF PROCEDURE 10000-69999. SEE APPENDIX II-B; CHAPTER 3336.	B 15	M 144
559	INVALID 4TH DIGIT FOR PROCEDURE CODE #2 (CLINICAL EDITOR).	B 18	
994	PROCEDURE CODE MODIFIER "50" - BILATERAL PROCEDURE IS NOT VALID FOR THE PROCEDURE CODE BILLED.	B 18	M 78
169	THE TWO-DIGIT MODIFIER BILLED IS NOT ALLOWED FOR THE PROCEDURE CODE BILLED OR FOR MODIFIERS 26 AND TC. THE MODIFIER IS NOT VALID FOR THIS PROCEDURE FOR THE SERVICE DATE BILLED. REFER TO YOUR MEDICAL ASSISTANCE LETTER FOR THE LIST OF VALID MODIFIERS AND EFFECTIVE DATES OF SERVICE.	B 18	M 78
555	INVALID PROCEDURE CODE - PROCEDURE CODE #2 (CLINICAL EDITOR).	B 18	
448	NONCOVERED PROCEDURE - PROCEDURE CODE #1 (CLINICAL EDITOR).	B 18	MA 66
445	INVALID 4TH DIGIT FOR PROCEDURE CODE #1 (CLINICAL EDITOR).	B 18	MA 66
442	INVALID PROCEDURE CODE-PROCEDURE CODE #1 (CLINICAL EDITOR).	B 18	MA 66
117	PROCEDURE CODE WAS BILLED WITH AN INVALID MODIFIER. REVIEW THE PROCEDURE CODE MODIFIER BILLED FOR ACCURACY. OHIO MEDICAID DOES NOT ACCEPT ALL MODIFIERS USED BY THE MEDICARE PROGRAM. REFER TO THE APPROPRIATE MEDICAID PROVIDER HANDBOOK FOR ASSISTANCE.	B 18	M 78
560	INVALID 4TH DIGIT FOR PROCEDURE CODE #3 (CLINICAL EDITOR).	B 18	
227	FOR DATES OF SERVICE ON OR AFTER 01/04/88, MODIFIERS 26 AND ZP ARE NOT ALLOWED FOR PROCEDURE 88150.	B 18	
446	NONSPECIFIC PROCEDURE - PROCEDURE CODE #1 (CLINICAL EDITOR).	B 18	MA 66
437	MANIFESTATION PRINCIPLE DIAGNOSIS. (CLINICAL EDITOR).	B 22	
A 90	LTCF PENALTY DUE TO THE LATE FILING OF THEIR COST REPORT AND OR FACILITY CAPACITY REPORT.	B 4	
957	SERVICE IS LIMITED TO 1 EVERY 270 DAYS.	B 5	
278	THIS PATIENT IS A QUALIFIED MEDICARE BENEFICIARY. ONLY MEDICARE-X-OVER CLAIMS SHOWING A DEDUCTIBLE/OR COINSURANCE ARE PAYABLE BY MEDICAID. CONTACT COUNTY HUMAN SERVICES DEPT. IF ELIGIBILITY IS QUESTIONED.	B 5	N 18
A 98	LTCF CIVIL MONETARY PENALTY (CMP) FINE.	B 5	

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577	THE PROVIDER TYPE IN THE CLAIM RECORD IS 13 OR 16 AND THE RECIPIENT'S WAIVER PROGRAM INDICATOR IS NOT EQUAL TO E, F, G, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, 2, 4 5, 7 OR 8.	B 5	N 30
572	FOR PROC CODE X0102; BILLED QUANTITY IS LESS THAN 8 UNITS OR IS GREATER THAN 24 UNITS.	B 5	
926	THE RECIPIENT'S WAIVER PROGRAM INDICATOR IS EQUAL TO A, 1, 2, 4 OR 5 AND A LINE ITEM PROCEDURE CODE IS EQUAL TO Z8002. THE RECIPIENT IS ENROLLED IN THE PASSPORT WAIVER PROGRAM AND IS NOT ELIGIBLE TO RECEIVE THIS SERVICE.	B 5	N 30
854	THE CLAIM WAS CREATED FROM A MASS ADJUSTMENT OR A MASS CREDIT FOR THE DELOITTEE-TOUCHE MEDICARE RECOUPMENT PROJECT.	B 5	
A O9	THE PATIENT HAS EXCEEDED THE NUMBER OF VISITS LIMITATION.	B 5	
578	PROVIDER TYPE IN THE CLAIM RECORD IS 17, 18, 52, 76, 82, 83, 86, 87, 88, 89 OR 90 AND THE RECIPIENT'S WAIVER PROGRAM INDICATOR IS NOT EQUAL TO E, F, G, I, J, K, L, M, N, O, P, Q, R, S, T, 7 OR 8.	B 5	N 30
583	PROVIDER TYPE IN THE CLAIM RECORD IS 17 OR 18 AND A LINE ITEM PROCEDURE CODE IS Z8002 OR Z8501 THROUGH Z8508 AND THE RECIPIENT'S WAIVER PROGRAM INDICATOR IS NOT EQUAL TO E, F, G, I,J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, 7 OR 8.	B 6	N 30
476	PASSPORT PROVIDER BILLING FOR OTHER THAN PP474, PP476, PP477, PP478, PP495, PP500 THRU PP507.	B 6	
566	PAYMENT OF MEDICARE PART B COINSURANCE AND DEDUCTIBLES TO LTCF ARE RESTRICTED TO DME HCPCS. AT LEAST ON LINE ITEM, PROCEDURE CODE IS NOT LISTED AMONG THE LIST OF DME HCPCS PROCEDURE CODES THAT ARE PAYABLE FOR COMMON CLAIM MEDICARE PART B X-OVER CLAIMS.	B 6	M 20
585	THE CATEGORY OF SERVICE IN THE CLAIM IS 66 AND THE RECIPIENT'S WAIVER PROGRAM INDICATOR IS NOT EQUAL TO 'A' (PASSPORT 3) OR 2' (PASSPORT - WAIVER & CORE SERVICE).	B 7	N 30
580	PROVIDER TYPE IN THE CLAIM RECORD IS 86, 87, 88, 89 OR 90 AND A LINE ITEM PROCEDURE CODE IS NOT EQUAL TO Z8507.	B 7	
582	PROVIDER TYPE IN THE CLAIM RECORD IS 17 OR 18 AND A LINE ITEM PROCEDURE CODE IS NOT EQUAL TO Z8002.	B 7	
846	PROVIDER TYPE IS 77 (HMO) FOR COMMON CLAIM FORM AND A PROCEDURE CODE LISTED IS NOT X5400 - X5500.	B 7	

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733	THE PROVIDER TYPE OF THE SERVICING PROVIDER IN THE CLAIM RECORD IS NOT ELIGIBLE TO RENDER SERVICES TO GENERAL ASSISTANCE OR DISABILITY ASSISTANCE RECIPIENTS. NON-REIMBURSABLE PROVIDER TYPES ARE 10, 27, 35, 37, 38, 39, 40, 42, 44, 45, 47, 55, 60, 69 AND 75.	B 7	
918	PROVIDER ENROLLMENT STATUS = 8 - NO SIGNED CORE AGREEMENT.	B 7	
915	THE PROVIDER NUMBER AS SHOWN ON THIS REMITTANCE ADVICE HAS BEEN TERMINATED WITH A PROVIDER DECEASED STATUS.	B 7	
268	LONG-TERM CARE CLAIM PROVIDER # DOES NOT AGREE WITH PROVIDER # IN RECIPIENT FILE.	B 7	MA 134
424	PAY-TO-PROVIDER IS NOT ENROLLED OR IS NOT ELIGIBLE FOR THE SERVICE DATES BILLED.	B 7	
266	PACT CASE MANAGEMENT FEE (X0690) IS BILLED AND THE RENDERING PROVIDER IS NOT THE DESIGNATED PACT PROVIDER.	B 7	
422	PROVIDER WAS NOT ELIGIBLE ON THE CLAIM DATES OF SERVICE. CONTACT PROVIDER RELATIONS.	B 7	
265	PACT CASE MANAGEMENT FEE, X0690, IS BILLED AND NO PACT SPAN IS PRESENT FOR THE DATE OF SERVICE.	B 7	
149	AN ENCOUNTER PROCEDURE CODE WAS ENTERED ON THE INVOICE AND THE SERVING PROVIDER IS NOT ENROLLED AS A CLINIC. FOR THE 6780 INVOICE VERIFY THAT THE PROVIDER SERVICE IN BLOCK 4 IS A "Q". FOR THE HCFA-1500 VERIFY THE PROVIDER NUMBER ENTERED IN BLOCK 33 IS FOR A CLINIC PROVIDER.	B 7	N 95
917	PROVIDER ENROLLMENT STATUS = 7 - PROVIDER CHANGED NUMBER.	B 7	
912	YOUR MEDICAID PROVIDER NUMBER IS PENDING UNTIL THE DEPARTMENT HAS COMPLETED OUR REVIEW OF YOUR PROVIDER APPLICATION. CONTACT THE PROVIDER ENROLLMENT UNIT FOR ADDITIONAL INFORMATION AT 1-800-686-6108 (IN STATE) 614-728-3288 (OUT OF STATE).	B 7	
909	PROVIDER STATUS EQUALS "I" - STATE INITIATED.	B 7	
906	YOUR MEDICAID PROVIDER NUMBER HAS BEEN TERMINATED. THE TERMINATION WAS STATE INITIATED. CONTACT THE PROVIDER ENROLLMENT UNIT AT 1-800-686-6108 (IN STATE) 614-728-3288 (OUT OF STATE).	B 7	
905	YOUR WERE INADVERTENTLY ASSIGNED A SECOND MEDICAID PROVIDER NUMBER. THE PROVIDER NUMBER SHOWING ON THIS REMITTANCE ADVICE HAS BEEN TERMINATED. CONTACT PROVIDER ENROLLMENT AT 1-800-686-6108 (IN STATE) 614-728-3288 (OUT OF STATE).	B 7	

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903	YOUR MEDICAID PROVIDER NUMBER HAS BEEN TERMINATED. THE TERMINATION WAS BASED ON THE STATE BOARD NOT RENEWING YOUR CERTIFICATION/LICENSE.	B 7	
902	YOUR MEDICAID PROVIDER NUMBER HAS BEEN TERMINATED. THIS TERMINATION WAS BASED ON THE STATE BOARD REVOCATION OF YOUR CERTIFICATION/LICENSE.	B 7	
901	YOUR MEDICAID PROVIDER NUMBER HAS BEEN TERMINATED. THIS TERMINATION WAS FEDERALLY INITIATED.	B 7	
102	THIS CLAIM IS A POSSIBLE DUPLICATE OF AN ALREADY PAID CLAIM. FOR THIS REMITTANCE ADVICE, NOTE THE PAID REFERENCE LINE CORRESPONDING TO THE DUPLICATE CLAIM REJECTION. USING THE PAID REFERENCE LINE NUMBER REFER TO THE LAST PAGE OF THIS REMITTANCE ADVICE FOR CLAIM PAYMENT INFORMATION.	B13	
590	THE RECIPIENT'S WAIVER PROGRAM INDICATOR IS BLANK AND A LINE ITEM PROCEDURE CODE IS EQUAL TO Z8501 THROUGH Z8508.	B5	N 30
641	EARLY REFILL - CALL 877-518-1545 (NCPDP EDIT 79, FIRST HEALTH POS EDIT 131).	B5	
656	INVALID PROCEDURE FOR MENTAL RETARDATION SERVICES PROVIDER.	B6	MA 66
652	FOR PROCEDURE CODE W3002, THE RECIPIENT MUST BE PARTICIPATING IN A HCBS WAIVER WITH ICF-MR LEVEL OF CARE.	B6	N 30
657	THE CATEGORY OF SERVICE IN THE CLAIM RECORD IS "86"; NURSING HOME THERAPIES AND THE PROVIDER TYPE IN THE CLAIM RECORD IS NOT '86'; SNF OR '87'; ICF. PROVIDERS ENROLLED AS ICF-MR PRIVATE OR PUBLIC ARE NOT ELIGIBLE FOR NURSING HOME THERAPY REIMBURSEMENT.	B6	
658	FOR OUTPATIENT CLAIMS, THE PROVIDER TYPE IN THE CLAIM RECORD IS '86' OR '87' AND THE TYPE-OF-BILL IS NOT '231'. ALL CLAIMS SUBMITTED FOR NURSING HOME THERAPIES MUST BE SUBMITTED USING THIS TYPE-OF-BILL.	B6	MA 30
478	NDC FOR COMPOUND ONLY/CONFLICT (NCPDP EDIT 70, FIRST HEALTH POS EDIT 208).	D-2	
A 76	LTCF INTERIM SETTLEMENT RECOUPMENT.	IS *	
A 78	LTCF FINAL SETTLEMENT RECOUPMENT.	IS *	
A 84	LTCF INTERIM SETTLEMENT PAYMENT.	IS *	
A 87	LTCF QUARTERLY RATE SETTLEMENT PAYMENT.	IS *	
A 79	LTCF QUARTERLY SETTLEMENT RECOUPMENT.	IS *	
AB	LIEN AMOUNT TAKEN FROM PROVIDER.	LE *	

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925	FOR ALL CLAIM TYPES EXCEPT INPATIENT HOSPITAL; THE RECIPIENT WAS ENROLLED IN THE GENERAL ASSISTANCE OR DISABILITY ASSISTANCE PROGRAM AND THE FIRST DATE OF SERVICE IS PRIOR TO 07/01/92. FOR INPATIENT HOSPITAL, THE DATE OF DISCHARGE IS PRIOR TO 07/01/92. BILL COUNTY DJFS FOR PAYMENT.	NA	
671	MATERNAL CHILD CLINICS; PROCEDURE X5411, X5412, X5422, X5431 AND/OR X5500 WAS BILLED BUT NO POST PARTUM SERVICE (PROC 59410, 59430, 59510) WAS FOUND ON PAID CLAIMS HISTORY. PROCEDURES 59410, 59430 OR 59510 MUST HAVE BEEN PAID BEFORE THESE SERVICES CAN BE SUBMITTED FOR PAYMENT.	NA	
A 29	TOUCHE ROSS HAS DISCOVERED/RECOVERED MEDICAID OVERPAYMENT RELATIVE TO MEDICARE A, B, OR OTHER INSURANCE.		MA 74
ZZ	SUSPENDED RECOUPMENT.		
A 07	INFORMATION ON THE ORIGINAL INVOICE DIFFERS FROM THAT ON THE REMITTANCE ADVICE.		
496	COVERAGE STATUS NOT DETERMINED (NCPDP EDIT 70, FIRST HEALTH POS EDIT 209).		
495	THE PROVIDER TYPE OF THE SERVICING PROVIDER IS THAT OF A DIALYSIS CLINIC. MEDICARE X-OVER CLAIMS FOR THIS PROVIDER TYPE MUST BE SUBMITTED USING THE UB INVOICE. USE OF THE 6780 COMMON CLAIM FORM IS RESERVED FOR FEE-FOR-SERVICE CLINICAL CLAIM SUBMISSIONS ONLY.		
419	USE FORMULARY NDC, SEE MANUAL (NCPDP EDIT 75, FIRST HEALTH POS EDIT 205).		M119
A 55	MEDICARE CROSSOVER PAYMENT WAS MADE TO THE WRONG PROVIDER.		
A 85	LTCF GROSS ADJUSTMENT OF RETROACTIVE RATE INCREASE.		
A 7X	LTCF FINAL SETTLEMENT RCP INT.		
BB	MEDICAID RECOUPMENT AMOUNT TEMPORARILY SUSPENDED.		
A 08	THE SURGERY CLAIM HAS BEEN REVIEWED BY THE MEDICAL CON. UNIT (MTA).		
A 91	THIRD-PARTY SECTION RECOVER DUE TO HEALTH INSURANCE.		
A 92	THIRD-PARTY SECTION RECOVER DUE TO TORT SETTLEMENTS OR WORKER'S COMPENSATION.		
A 77	LTCF GROSS ADJUSTMENT RECOUPMENT OF RETRO RATE DECREASE.		
A 93	THIRD-PARTY SECTION HAS RECEIVED CHECKS FROM THE COUNTY CHILD SUPPORT ENFORCEMENT AGENCY.		
A 97	LTCF NON-CERTIFIED NON-COVERED DAYS.		