Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0000	01/01/1900	THIS CLAIM/SERVICE IS PENDING FOR PROGRAM REVIEW.
0001	01/01/1900	NOT USED - MEMBER'S DMAP I.D. NUMBER IS MISSING OR INCORRECT
0002	01/01/1900	COULD NOT PROCESS CLAIM. PLEASE RESUBMIT CLAIM LATER.
0003	01/01/1900	A MINIMUM OF ONE DETAIL IS REQUIRED.
0004	01/01/1900	DME RENTAL BEYOND THE INITIAL 30 DAY PERIOD IS NOT PAYABLE WITHOUT PRIOR AUTHORIZATION.
0007	01/01/1900	INFORMATION INADEQUATE TO ESTABLISH MEDICAL NECESSITY OF PROCEDURE PERFORMED.PLEASE RESUBMIT WITH ADDITIONAL SUPPORTING DOCUMENTATION.
0010	01/01/1900	MEMBER IS ENROLLED IN MEDICARE PART A AND/OR PART B ON THE DISPENSE DATE OF SERVICE.
0014	01/01/1900	DISCREPANCY EXISTS BETWEEN OTHER COVERAGE CODE AND THE OTHER PAYER PAID AMOUNT.
0015	01/01/1900	MEMBER IS ENROLLED IN MEDICARE PART D ON THE DATE(S) OF SERVICE.
0019	01/01/1900	MEDICARE PAID THE TOTAL ALLOWABLE FOR THE SERVICE.
0021	01/01/1900	PROCEDURE CODE IS ALLOWED ONCE PER MEMBER PER LIFETIME.
0022	01/01/1900	BILLING PROVIDER NPI AND TAXONOMY COMBINATION IS INVALID. RESUBMIT WITH THE VALID ENROLLED TAXONOMY.
0024	01/01/1900	PROVIDER ON PREPAYMENT REVIEW
0025	01/01/1900	BILLING PROVIDER IS NO LONGER ENROLLED FOR THE FROM AND/OR TO DATE OF SERVICE.
0029	01/01/1900	LAST NAME DOES NOT MATCH MEMBER ID.
0030	01/01/1900	PRESCRIBING/REFERRING/ORDERING PROVIDER IS NOT CURRENTLY ENROLLED.
0031	01/01/1900	PROCEDURE CONVERSION FACTOR MISSING FOR RBRVS PROCEDURE CODE.
0033	01/01/1900	THE MEMBER WAS NOT ELIGIBLE FOR THE DATE OF SERVICE ON YOUR CLAIM.
0037	01/01/1900	CLAIM DENIED. CONSENT FOR STERILIZATION/HYSTERECTOMY ACKNOWLEDGEMENT/ABORTION NECESSITY FORM IS MISSING, INCOMPLETE, OR CONTAINS INVALID INFORMATION.
0039	01/01/1900	NOT USED - THE SERVICE REQUESTED IS NOT A COVERED BENEFIT OF THE DMAP PROGRAM.
0040	01/01/1900	RENDERING PROVIDER ID IS NOT ON FILE.
0044	01/01/1900	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
0045	01/01/1900	NOT USED - THE SERVICE REQUESTED DOES NOT CORRESPOND WITH DMAP AGE CRITERIA.
0047	01/01/1900	THESE CASE COORDINATION SERVICES EXCEED THE LIMIT.
0049	01/01/1900	MORE THAN 6 HOURS OF EVALUATION/ASSESSMENT IN A 2 YEAR PERIOD MUST BE BILLED ASTREATMENT SERVICES AND COUNT TOWARD THE MH/SA POLICY LIMITS FOR PRIOR AUTHORIZATION.
0051	01/01/1900	THE HEADER FROM AND TO DATES OF SERVICE CANNOT BE THE SAME.
0052	01/01/1900	THE ADMIT DATE IS REQUIRED.
0056	01/01/1900	FUTURE DATE OF SERVICE NOT ALLOWED.
0058	01/01/1900	PROCEDURE BILLED IS NOT ON THE RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) FILE.

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0060	01/01/1900	ADMIT DIAGNOSIS IS REQUIRED.
0064	01/01/1900	CLAIM REDUCED TO FIFTEEN HOSPITAL BEDHOLD DAYS FOR STAYS EXCEEDING FIFTEEN DAYS.
0074	01/01/1900	BILLING PROVIDER IS RESTRICTED FROM SUBMITTING ELECTRONIC CLAIMS.
0077	01/01/1900	REND PROV CONTRACT NOT VALID ON DOS - DTL
0080	01/01/1900	DIAGNOSIS CODE SUBMITTED IS NOT APPROPRIATE FOR SERVICE BILLED.
0081	01/01/1900	NOT USED - AMOUNT PAID BY OTHER INSURANCE EXCEEDS AMOUNT ALLOWED BY DMAP.
0082	01/01/1900	PRIOR AUTHORIZATION NUMBER CHANGED TO PERMIT APPROPRIATE CLAIMS PROCESSING.
0084	01/01/1900	PROVIDER SIGNATURE AND/OR DATE REQUIRED.
0086	01/01/1900	CLAIM CANNOT CONTAIN BOTH CONDITION CODES A5 AND X0 ON THE SAME CLAIM. PLEASERESUBMIT CHARGES FOR EACH CONDITION CODE ON A SEPARATE CLAIM.
0091	01/01/1900	A VALID ENROLLED PRESCRIBING/REFERRING/ORDERING PROVIDER NPI IS REQUIRED.
0093	01/01/1900	FIRST MODIFIER CODE IS INVALID FOR DATE OF SERVICE.
0094	01/01/1900	REFILL INDICATOR MISSING OR INVALID. PLEASE CORRECT AND RESUBMIT.
0095	01/01/1900	DAW NOT ACCEPTED.
0100	01/01/1900	DENIED AS DUPLICATE CLAIM. SERVICES ON THIS CLAIM WERE PREVIOUSLY PARTIALLY PAID OR PAID IN FULL.
0101	01/01/1900	THIS DETAIL IS DENIED AS IT IS A DUPLICATE OF ANOTHER DETAIL ON THE SAME CLAIMOR OF ANOTHER PAID DETAIL ON A PREVIOUS CLAIM.
0102	01/01/1900	DUPLICATE ITEM OF A CLAIM BEING PROCESSED. PLEASE DO NOT FILE A DUPLICATE CLAIM.
0106	01/01/1900	INVALID MEDICARE DISCLAIMER SUBMITTED.
0110	01/01/1900	NOT USED - BENEFIT PAYMENT DETERMINED BY DMAP FISCAL AGENT REVIEW.
0112	01/01/1900	SERVICE CODE IS INVALID.
0114	01/01/1900	SCHEDULE 3, 4, 5 DRUGS LIMITED TO ORIGINAL FILL PLUS 5 REFILLS OR 6 MONTHS.
0115	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST.
0116	01/01/1900	PROCEDURE CODE IS NOT A BENEFIT ON DATE OF SERVICE.
0119	01/01/1900	YOU ARE BILLING FOR DATES OF SERVICE THAT SPAN PROGRAMS. CHECK ELIGIBILITY ANDRESUBMIT AS SEPARATE CLAIMS.
0120	01/01/1900	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAVEBEEN REDUCED.
0127	01/01/1900	RENDERING PROVIDER IS NOT ENROLLED UNDER BILLING GROUP NUMBER FOR DATES OF SERVICE BILLED
0128	01/01/1900	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
0130	01/01/1900	MEMBER HAS MEDICARE SUPPLEMENTAL COVERAGE FOR THE DATE(S) OF SERVICE.
0133	01/01/1900	THE ADMIT TYPE CODE IS INVALID.
0135	01/01/1900	DAW REQUIRED FOR BRAND INNOVATOR NDC.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0146	01/01/1900	NON-SCHEDULED DRUGS LIMITED TO ORIGINAL DISPENSING PLUS 11 REFILLS OR 12 MONTHS.
0148	01/01/1900	DISPENSING REPLACEMENT PARTS AND COMPLETE APPLIANCE ON SAME DATE OF SERVICE NOTALLOWED.
0152	01/01/1900	MEDICARE PAID AMOUNT(S) HAVE BEEN INCORRECTLY APPLIED TO BOTH THE CLAIM HEADERAND DETAILS.
0153	01/01/1900	THE HEADER TOTAL BILLED AMOUNT IS INVALID.
0156	01/01/1900	THE MEDICARE PAID AMOUNT IS MISSING OR INCORRECT.
0158	01/01/1900	QUANTITY BILLED IS MISSING OR EXCEEDS THE MAXIMUM ALLOWED PER DATE OF SERVICE.
0159	01/01/1900	A VALID HEADER MEDICARE PAID DATE IS REQUIRED.
0160	01/01/1900	MEDICARE ALLOWED AMOUNT WAS INCORRECT OR NOT PROVIDED ON CROSSOVER CLAIM.
0162	01/01/1900	MULTIPLE UNLOADED TRIPS FOR SAME DAY, SAME MEMBER, REQUIRE UNIQUE TRIP MODIFIERS. A CODE WITH NO TRIP MODIFIER BILLED ON SAME DAY AS A CODE WITH MODIFIER U1 ARE CONSIDERED THE SAME TRIP.
0164	01/01/1900	FREQUENCY OR NUMBER OF INJECTIONS EXCEED PROGRAM POLICY GUIDELINES.
0166	01/01/1900	THE PROCEDURE CODE BILLED NOT PAYABLE ACCORDING TO DEFRA.
0171	01/01/1900	CLAIM OR ADJUSTMENT RECEIVED BEYOND 365-DAY FILING DEADLINE.
0172	01/01/1900	MEMBER IS NOT ENROLLED FOR ALL DATES OF SERVICE BILLED.
0174	01/01/1900	DIALYSIS/EPO TREATMENT IS LIMITED TO 13 OR 14 SERVICES PER CALENDAR MONTH. IF IT IS MEDICAL NECESSARY FOR MORE THAN 13 OR 14 SERVICES PER CALENDAR MONTH, SUBMIT AN ADJUSTMENT REQUEST WITH SUPPORTING DOCUMENTATION.
0175	01/01/1900	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
0177	01/01/1900	A PLACE OF SERVICE CODE IS REQUIRED.
0182	01/01/1900	BILLING PROVIDER TYPE AND/OR SPECIALTY IS NOT ALLOWABLE FOR THE SERVICE BILLED.
0183	01/01/1900	PROVIDER NOT AUTHORIZED TO PERFORM PROCEDURE.
0184	01/01/1900	PROCEDURE CODE IS RESTRICTED BY MEMBER AGE.
0185	01/01/1900	PROCEDURE CODE BILLED IS NOT APPROPRIATE FOR MEMBER'S GENDER.
0186	01/01/1900	VISION EXAM LIMITED TO ONE PER YEAR.
0192	01/01/1900	PRIOR AUTHORIZATION (PA) IS REQUIRED FOR THIS SERVICE. AN APPROVED PA WAS NOT FOUND MATCHING THE PROVIDER, MEMBER, AND SERVICE INFORMATION ON THE CLAIM.
0200	01/01/1900	BILLING PROVIDER ID MISSING
0201	01/01/1900	RENDERING PROVIDER IS NOT CERTIFIED FOR THE DATE(S) OF SERVICE.
0202	01/01/1900	TABLET SPLITTING LIMITED TO 3 FEES, PER MEMBER, PER MONTH.
0203	01/01/1900	DAYS SUPPLY IS INVALID.
0205	01/01/1900	DETAIL RENDERING PROVIDER IS NO LONGER ENROLLED FOR THE DATE OF SERVICE
0208	01/01/1900	PREGNANCY INDICATOR INVALID

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0210	01/01/1900	THIS PROCEDURE CODE SHOULD BE USED WHEN DETERMINING THE BETA SUB-UNIT OF CHORIONIC GONADOTROPIN AND SHOULD NOT BE USED FOR ROUTINE PREGNANCY TESTS. THIS CLAIMWILL NOT BE PAID.
0212	01/01/1900	PROCEDUE CODE IS ALLOWED ONCE PER MEMBER PER CALENDAR YEAR.
0213	01/01/1900	THE SERVICE(S) BILLED ARE CONSIDERED PAID IN THE PAYMENT FOR THE SURGICAL PROCEDURE.
0218	01/01/1900	PRIOR AUTHORIZATION IS REQUIRED FOR SERVICE(S) EXCEEDING MENTAL HEALTH AND/OR SUBSTANCE ABUSE BENEFIT GUIDELINES.
0220	01/01/1900	TOOTH SURFACE IS INVALID OR NOT INDICATED.
0221	01/01/1900	THE DETAIL BILLED AMOUNT IS REQUIRED.
0224	01/01/1900	QUANTITY DISPENSED IS INVALID.
0226	01/01/1900	WELL-BABY VISITS ARE LIMITED TO 12 VISITS IN THE FIRST YEAR OF LIFE.
0229	01/01/1900	THE TYPE OF BILL IS INVALID.
0232	01/01/1900	SOURCE OF ADMIT IS MISSING OR INVALID.
0235	01/01/1900	DENIED/CUTBACK. PURCHASE OF ADDITIONAL DME/DMS ITEM EXCEEDING LIFE EXPECTANCY REQUIRES PRIOR AUTHORIZATION.
0238	01/01/1900	MEMBER ID CREATED FOR NEWBORN (K-BABY).
0240	01/01/1900	THE PRESCRIPTION REFILL NUMBER (FILL NUMBER) IS NOT NUMERIC.
0242	01/01/1900	PRESCRIPTION DATE IS INVALID.
0245	01/01/1900	NO DRUG REBATE AGREEMENT.
0247	01/01/1900	PROCEDURE CODE HAS BEEN TERMINATED BY CMS, AMA OR ADA FOR THE DATE OF SERVICE.
0250	01/01/1900	CLAIM HAS NO DETAILS
0254	01/01/1900	A VALID DETAIL MEDICARE PAID DATE IS REQUIRED
0259	01/01/1900	DATE BILLED IS MISSING/INVALID
0262	01/01/1900	TOOTH NUMBER IS INVALID
0263	01/01/1900	PRIOR AUTHORIZATION IS REQUIRED FOR MANIPULATIONS/ADJUSTMENTS EXCEEDING 20 PERSPELL OF ILLNESS.
0264	01/01/1900	SUBSEQUENT SURGICAL PROCEDURES ARE REIMBURSED AT REDUCED RATE.
0268	01/01/1900	MEMBER IS ENROLLED IN MEDICARE PART D FOR THE DISPENSE DATE OF SERVICE. PRESCRIPTION DRUG PLAN (PDP) PAYMENT/DENIAL INFORMATION IS REQUIRED ON THE CLAIM TO SENIORCARE.
0273	01/01/1900	RESUBMIT CHARGES FOR MEDICAID COVERED SERVICE(S) DENIED BY MEDICARE ON A MEDICAID CLAIM
0274	01/01/1900	COMPLEX CARE OF 17-PLUS HOURS AND COMPLEX CARE OF LESS THAN 17 HOURS ARE NOT ALLOWED ON THE SAME DATE OF SERVICE.
0275	01/01/1900	ADJUSTMENT/RECONSIDERATION REQUEST DENIED DUE TO INCORRECT/INSUFFICIENT INFORMATION. REVIEW BILLING INSTRUCTIONS. USE THIS CLAIM NUMBER IF YOU RESUBMIT.
0276	01/01/1900	THE SUM OF ALL VALUE CODE AMOUNTS MUST BE NUMERIC AND LESS THAN OR EQUAL TO 999.999.999.
0277	01/01/1900	NDC/PHARMACEUTICAL CARE INCLUDED IN NURSING HOME DAILY RATE.
0278	01/01/1900	MEMBER IS COVERED BY A COMMERCIAL HEALTH INSURANCE ON THE DATE(S) OF SERVICE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0281	01/01/1900	MEMBER ID IS REQUIRED.
0282	01/01/1900	INPATIENT PSYCHIATRIC SERVICES ARE NOT REIMBURSABLE FOR MEMBERS AGE 21 - 65 (AGE 22 IF RECEIVING SERVICES PRIOR TO 21ST BIRTHDAY).
0285	01/01/1900	SIX HOUR LIMITATION ON EVALUATION/ASSESSMENT SERVICES IN A 2 YEAR PERIOD HAS BEEN EXCEEDED. ADDITIONAL SERVCIES MAY BE BILLED WITH H0046 AND WILL COUNT TOWARDMENTAL HEALTH AND/OR SUBSTANCE ABUSE TREATMENT POLICY LIMITS FOR PRIOR AUTHORIZATION.
0287	01/01/1900	MEMBER IS ENROLLED IN A STATE-CONTRACTED MANAGED CARE PROGRAM FOR THE DATE(S) OF SERVICE. CLAIM SHOULD BE SUBMITTED TO THE MEMBER'S ASSIGNED MCO FOR PAYMENT.
0288	01/01/1900	THE REVENUE/HCPCS CODE COMBINATION IS INVALID.
0289	01/01/1900	OUT-OF-STATE NON-EMERGENCY SERVICES REQUIRE PRIOR AUTHORIZATION.
0295	01/01/1900	DOES NOT MEET HEARING AID PERFORMANCE CHECK REQUIREMENT OF 45 POST DISPENSING DAYS.
0303	01/01/1900	THE DATE OF THE SCREENING REQUEST OR THE DATE OF SCREENING IS INVALID OR MISSING. PLEASE CORRECT AND RESUBMIT.
0304	01/01/1900	HOSPICE UNITS BILLED ARE GREATER THAN DETAIL COVERED DATESPAN
0309	01/01/1900	CONSULTATION OR SURGICAL PROCEDURES ARE NOT REIMBURSABLE IN CONJUCTIONS WITH EMERGENCY ROOM SERVICES.
0310	01/01/1900	THE SPECIAL PACKAGING INDICATOR/UNIT DOSE INDICATOR IS INVALID
0316	01/01/1900	BACK-UP DIALYSIS SESSIONS ARE LIMITED TO THREE PER LIFETIME.
0319	01/01/1900	FOUR X-RAYS ARE ALLOWED PER SPELL OF ILLNESS PER PROVIDER.RECONSIDERATION WITH DOCUMENTATION WARRANTING MORE X-RAYS.
0320	01/01/1900	PCN ONLY REQUIRED FOR SENIORCARE/WCDP.
0321	01/01/1900	ORAL EXAMS OR PROPHYLAXIS IS LIMITED TO ONCE PER YEAR UNLESS PRIOR AUTHORIZED.
0325	01/01/1900	SERVICES HAVE BEEN DETERMINED BY DHCAA TO BE NON-EMERGENCY.
0334	01/01/1900	INPATIENT MENTAL HEALTH SERVICES PERFORMED BY MASTER'S LEVEL PSYCHOTHERAPISTS OR SUBSTANCE ABUSE COUNSELORS ARE NOT COVERED.
0335	01/01/1900	THE COMPREHENSIVE COMMUNITY SUPPORT PROGRAM REIMBURSEMENT LIMITATIONS HAVE BEENEXCEEDED.
0336	01/01/1900	REIMBURSEMENT LIMITS FOR COMMUNITY CARE SERVICES FOR THE CALENDAR YEAR ARE CLOSE TO BEING EXCEEDED.
0344	01/01/1900	MEDICATION CHECKS BY A PSYCHIATRIST AND/OR REGISTERED NURSE ARE LIMITED TO FOURSERVICES PER CALENDAR MONTH.
0350	01/01/1900	REIMBURSEMENT IS LIMITED TO ONE "MAXIMUM ALLOWABLE FEE" PER DAY PER PROVIDER.
0361	01/01/1900	DISPENSING FEE DENIED. ONLY TWO DISPENSING FEES PER MONTH, PER MEMBER ALLOWED.
0365	01/01/1900	CLAIM DENIED/CUTBACK. PURCHASE OF A DME/DMS ITEM EXCEEDING ONE PER MONTH REQUIRES PRIOR AUTHORIZATION.
0366	01/01/1900	NON-PREFERRED DRUGS REQUIRE PA.
0369	01/01/1900	34 DAYS SUPPLY OR LESS REQUIRED FOR NDC.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0376	01/01/1900	DAYS SUPPLY EXCEEDS ALLOWED LIMIT.
0378	01/01/1900	TOOTH NUMBER OR LETTER IS NOT VALID WITH THE PROCEDURE CODE FOR THE DATE OF SERVICE.
0386	01/01/1900	EYEGLASSES LIMITED TO ORIGINAL PLUS 1 REPLACEMENT PAIR, LENS OR FRAME IN 12 WITHOUT PRIOR AUTHORIZATION.
0388	01/01/1900	A VALID PROCEDURE CODE IS REQUIRED.
0389	01/01/1900	HEADER FROM DATE OF SERVICE IS REQUIRED.
0398	01/01/1900	A VALID PRIOR AUTHORIZATION IS REQUIRED.
0399	01/01/1900	DATE OF SERVICE MUST FALL BETWEEN THE PRIOR AUTHORIZATION GRANT DATE AND EXPIRATION DATE.
0402	01/01/1900	CLAIM OR ADJUSTMENT/RECONSIDERATION REQUEST MUST HAVE BOTH A REVENUE CODE AND EITHER A HCPCS CODE OR CPT CODE.
0404	01/01/1900	THE MEMBER HAS NO LEVEL OF CARE (LOC) AUTHORIZATION ON FILE.
0408	01/01/1900	THE DIAGNOSIS CODE IS NOT COVERED FOR THE MEMBER.
0409	01/01/1900	NO REIMBURSEMENT RATES ON FILE FOR THE DATE(S) OF SERVICE.
0411	01/01/1900	TIMELY FILING DEADLINE EXCEEDED. NO SUPPORTING DOCUMENTATION. PLEASE REFER TO THE ALL PROVIDER HANDBOOK FOR INSTRUCTIONS.
0413	01/01/1900	INITIAL VISIT/EXAM LIMITED TO ONCE PER LIFETIME PER PROVIDER.
0414	01/01/1900	REIMBURSEMENT OF THIS SERVICE IS INCLUDED IN THE REIMBURSEMENT OF THE MOST COMPLEX/COMPLETE PROCEDURE PERFORMED.
0415	01/01/1900	PAYMENT REDUCED. ALL RENTAL PAYMENTS HAVE BEEN DEDUCTED FROM THE PURCHASE COSTSINCE THE DME ITEM WAS RENTED AND SUBSEQUENTLY PURCHASED FOR THE MEMBER.
0416	01/01/1900	SERVICE DENIED, REFER TO MEDICARE'S BILLING AND/OR POLICY GUIDELINES.
0420	01/01/1995	PRESCRIBER REQUIRED TO CONTACT DAPO FOR OVERRIDE TO EXCEED 5 OPIOID RXS/MONTH.
0421	01/01/1995	BENCHMARK PLAN, CORE PLAN AND BASIC PLAN LIMITED TO 5 OPIOID RXS/MONTH.
0422	01/01/1900	MEMBER LIMITED TO ONE ANTIPSYCHOTIC DRUG/MONTH. ATTESTATION REQUIRED TO EXCEED.
0423	01/01/1900	ANTIPSYCHOTIC PA REQUIRED FOR CHILDREN.
0424	01/01/1900	BILLING PROVIDER ID IS NOT ON FILE.
0428	01/01/1900	TRAUMA/ACCIDENT CLAIM
0433	01/01/1900	MEDICARE DEDUCTIBLE AMOUNT INVALID
0434	01/01/1900	MEDICARE COINSURANCE AMOUNT INVALID
0439	01/01/1900	SERVICE(S) PAID AT THE MAXIMUM DAILY AMOUNT PER PROVIDER PER MEMBER.
0440	01/01/1900	HEARING AID REPAIRS ARE LIMITED TO ONCE PER SIX MONTHS, PER PROVIDER, PER HEARING AID.
0443	01/01/1900	REPAIR SERVICES BILLED IN EXCESS OF THE AMOUNT SPECIFIED IN THE DURABLE MEDICALEQUIPMENT (DME) HANDBOOK REQUIRE PRIOR AUTHORIZATION.
0446	01/01/1900	THIS SERVICE IS PAYABLE AT A FREQUENCY OF ONCE PER 12-MONTH PERIOD, PER PROVIDER, PER HEARING AID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0455	01/01/1900	DATE(S) OF SERVICE ON DETAIL MUST BE WITHIN A SUNDAY THRU SATURDAY CALENDAR WEEK.
0473	01/01/1900	ONE OR MORE ICD PROCEDURE CODE IS INVALID IN POSITIONS 6-24
0477	01/01/1900	BILLING PROVIDER INDICATED IS NOT CERTIFIED AS A BILLING PROVIDER.
0485	01/01/1900	QUANTITY LIMIT EXCEEDED.
0491	01/01/1900	TO ALLOW FOR MEDICARE PRICING CORRECT DETAIL DENIALS AND RESUBMIT.
0495	01/01/1900	RESUBMIT WITH LEGIBLE MEDICARE EOMB SHOWING VALID PAID DATE.
0498	01/01/1900	PHARMACEUTICAL CARE MUST BE BILLED WITH A LEVEL OF EFFORT.
0503	01/01/1900	MEMBER IS ENROLLED IN MEDICARE PART C ON THE DATE(S) OF SERVICE.
0505	01/01/1900	MEMBER OVER 65 BILL MEDICARE
0506	01/01/1900	DATE BILLED IS AFTER ICN
0509	01/01/1900	BILLED AND ALLOWED AMOUNTS EXCEED A VARIANCE THRESHOLD.
0510	01/01/1900	A VALID PRIOR AUTHORIZATION IS REQUIRED.
0511	01/01/1900	THIS NATIONAL DRUG CODE (NDC) IS ONLY PAYABLE AS PART OF A COMPOUND DRUG.
0513	01/01/1900	THIS CLAIM WAS PROCESSED AS A MEDICARE C ADVANTAGE PLAN CLAIM.
0521	01/01/1900	NOT USED - THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVEREDBY DMAP.
0540	01/01/1900	CLAIM IS LOCKED FROM VOIDS OR ADJUSTMENTS
0541	01/01/1900	CLAIM IS LOCKED FROM ADJUSTMENTS
0543	01/01/1900	PLEASE INDICATE QUANTITY DISPENSED.
0545	01/01/1900	MEMBER ENROLLED IN MEDICARE PART D. SUBMIT CLAIM TO MEDICARE PART D PLAN.
0558	01/01/1900	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
0570	01/01/1900	HEADER TOTAL DAYS ARE LESS THAN COVERED DAYS
0573	01/01/1900	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
0585	01/01/1900	FAMILY PLANNING INDICATOR IS INVALID.
0587	01/01/1900	SUPPLEMENTAL TESTS BILLED ON THE SAME DATE OF SERVICE AS VISION EXAMINATION ARENOT PAYABLE.
0589	01/01/1900	QTY AND/OR DETAIL CHARGE DO NOT DIVIDE OUT EQUALLY FOR DATES OF SERVICE AND/ORQTY GIVEN.
0592	01/01/1900	ASSESSMENT LIMIT PER CALENDAR YEAR HAS BEEN EXCEEDED. ADDITIONAL SERVICES MUSTBE BILLED AS TREATMENT SERVICES AND COUNT TOWARDS THE MENTAL HEALTH AND/OR SUBSTANCE ABUSE TREATMENT POLICY FOR PRIOR AUTHORIZATION.
0594	01/01/1900	BILLING PROVIDER IS NOT CERTIFIED FOR SUBSTANCE ABUSE DAY TREATMENT FOR THE DATE(S) OF SERVICE.
0595	01/01/1900	THE SERVICE WAS PREVIOUSLY PAID FOR THIS DATE OF SERVICE.
0599	01/01/1900	ATTACHMENT CONTROL NUMBER IS MISSING. RESUBMIT WITH AN ATTACHMENT CONTROL NUMBER.
0609	01/01/1900	ANCILLARY CODES ARE REIMBURSABLE ONLY FOR PAYABLE IN-HOUSE ACCOMMODATION DATESOF SERVICE.
0610	01/01/1900	DELIVERY ROOM UNITS EXCEED LIMIT OF ONE PER DAY

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0611	01/01/1900	FIRST TWO CHARACTERS (SUB-CONTRACTOR ID) OF THE CCO ICN IS MISSING OR INVALID
0613	01/01/1900	SERVICES SUBMITTED ON IMPROPER CLAIM FORM. REBILL USING CORRECT CLAIM FORM AS INSTRUCTED IN YOUR HANDBOOK.
0614	01/01/1900	FIRST NAME DOES NOT MATCH MEMBER ID.
0616	01/01/1900	CCO DENIED CHIP ENCOUNTERS BASED ON CAS RSN CODES
0618	01/01/1900	REPACKAGING NOT ALLOWED FOR NDC.
0619	01/01/1900	CCO CHP BLN PROVIDER NOT FOUND ON AFFILIATION FILE
0620	01/01/1900	CONTINUOUS HOME CARE MUST BE BILLED IN AN HOURLY QUANTITY EQUAL TO OR GREATER THAN EIGHT HOURS, UP TO AND INCLUDING 24 HOURS.
0621	01/01/1900	HOSPICE MEMBER SERVICES RELATED TO THE TERMINAL ILLNESS MUST BE BILLED BY HOSPICE OR ATTENDING PHYSICIAN.
0622	01/01/1900	CONTINUOUS HOME CARE AND ROUTINE HOME CARE MAY NOT BE BILLED FOR THE SAME MEMBER ON THE SAME DATE OF SERVICE.
0627	01/01/1900	DOCUMENTATION TO DETERMINE MEDICAL NECESSITY REQUIRED.
0628	01/01/1900	Missing or Invalid COB Paid Amount
0629	01/01/1900	MULTIPLE SERVICES PERFORMED ON THE SAME DAY MUST BE SUBMITTED ON THE SAME CLAIM. IF SOME OF THE SERVICES WERE PREVIOUSLY PAID, SUBMIT AN ADJUSTMENT/RECONSIDERATION REQUEST FOR THE PAID CLAIM.
0630	01/01/1900	NOT A SPECIALTY DRUG, AS THIS DRUG HAS A NADAC PRICE
0631	01/01/1900	MEMBER ASSIGNED TO LOCK-IN PROGRAM.
0633	01/01/1900	CLOZAPINE MANAGEMENT IS LIMITED TO ONE HOUR PER SEVEN-DAY TIME PERIOD PER PROVIDER PER MEMBER.
0635	01/01/1900	AMITIZA 8 MCG IS INDICATED FOR TREATMENT OF IRRITABLE BOWEL SYNDROME CONSTIPATION IS FEMALES ONLY.
0636	01/01/1900	PROGRAM CLAIM LIMIT EXCEEDED.
0637	01/01/1900	OTHER PAYER AMOUNT PAID CANNOT BE A NEGATIVE AMOUNT
0638	01/01/1900	DENIED/CUTBACK. SERVICE(S) EXCEEDS FOUR HOUR PER DAY PROLONGED/CRITICAL CARE POLICY. IF IT IS MEDICALLY NECESSARY TO EXCEED THE LIMITATION, SUBMIT AN ADJUSTMENT/RECONSIDERATION REQUEST WITH SUPPORTING DOCUMENTATION.
0639	01/01/1900	CLINICIAN ADMINISTERED DRUGS AND DEVICES- BILLED WITH PLACE OF SERVICE 11.
0640	01/01/1900	THE MAXIMUM NUMBER OF DETAILS IS EXCEEDED.
0643	01/01/1900	BILLING PROVIDER IS NOT CERTIFIED FOR THE DETAIL FROM DATE OF SERVICE.
0645	01/01/1900	THE PAYER ID DOES NOT MATCH THE CARRIER CODE ON THE CARRIER TABLE.
0646	01/01/1900	BENEFICIARY IS PREGNANT (PREGNANCY INDICATOR = 2) BUT THE GENDER OF THE BENEFICIARY IS NOT FEMALE.
0651	01/01/1900	ONE RN HH/RN SUPERVISORY VISIT IS ALLOWED PER DATE OF SERVICE PER PROVIDER PERMEMBER.
0652	01/01/1900	SUPERVISORY VISITS FOR UNSKILLED CASES ALLOWED ONCE PER 60-DAY PERIOD.
0653	01/01/1900	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.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0656	01/01/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE FIRST DIAGNOSIS CODE.
0657	01/01/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE SECOND DIAGNOSIS CODE.
0658	01/01/1900	THE QUANTITY BILLED FOR THIS SERVICE MUST BE IN WHOLE OR HALF HOUR INCREMENTS(.5) INCREMENTS.
0659	01/01/1900	DENTAL SERVICE IS LIMITED TO ONCE EVERY SIX MONTHS WITHOUT PRIOR AUTHORIZATION(PA).
0664	01/01/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE THIRD DIAGNOSIS CODE.
0668	01/01/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE FOURTH DIAGNOSIS CODE.
0669	01/01/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE FIFTH DIAGNOSIS CODE.
0670	01/01/1900	COMPOUND DRUG REQUIRES PA
0671	01/01/1900	DENIED/CUBACK. RISK ASSESSMENT/CARE PLAN IS LIMITED TO ONE PER MEMBER PER PREGNANCY.
0672	01/01/1900	USUAL CUSTOMARY CHRG-TOTAL CHG AMT-MISSING OR ZERO
0673	01/01/1900	MORE THAN 3 DAYS SUPPLY NOT ALLOWED FOR 72 HOUR EMERGENCY
0674	01/01/1900	THIS NDC IS A NONPREFERRED PACKAGE SIZE. SEE PDL FOR PREFERRED PKG. SIZE.
0675	01/01/1900	MISSING OR INVALID CCO ALLOWED AMOUNT
0676	01/01/1900	THE COMPOUND INGREDIENT BASIS OF COST DETERMINATION IS MISSING (SPACES) OR IT DOES NOT MATCH ONE OF THE VALID VALUES SPECIFIED FOR THE FIELD.
0677	01/01/1900	INVALID DAYS SUPPLY
0678	01/01/1900	BILLING PROVIDER TYPE AND SPECIALTY IS NOT ALLOWABLE FOR THE RENDERING PROVIDER.
0679	01/01/1900	THE SURGICAL PROCEDURE CODE OF GREATEST SPECIFICITY MUST BE USED.
0680	01/01/1900	COST EXCEEDS MAX ALLOWED/CLAIM ($1000.00-$4999.99)
0681	01/01/1900	COST EXCEEDS MAX ALLOWED PER CLAIM (>=$5000.00).
0682	01/01/1900	BILL INJECTABLE SCHEDULE II DRUGS ON A MEDICAL CLAIM FORM
0683	01/01/1900	GENERIC DRUG REQUIRED. IF BRAND IS MEDICALLY NECESSARY PRESCRIBER MUST SUBMIT PA REQUEST.
0685	01/01/1900	QUANTITY PRESCRIBED REQUIRED WHEN BILLING DEA SCHEDULE II DRUGS
0689	01/01/1900	NEUPOGEN SYRINGES ARE NON-PREFERRED. PLEASE DISPENSE PREFFERRED NEUPOGEN VIALS.
0690	01/01/1900	PA REQUIRED FOR NONPREFERRED DRUG
0691	01/01/1900	INSULIN PEN NON PREFERRED IN LTC
0692	01/01/1900	M/I USUAL & CUSTOMARY CHARGE
0693	01/01/1900	THIS DENTAL SERVICE LIMITED TO ONCE PER FIVE YEARS.PRIOR AUTHORIZATION IS NEEDED TO EXCEED THIS LIMIT.
0695	01/01/1900	PA REQUIRED FOR NON-PREFERRED BRAND. PRESCRIBER MAY SUBMIT BRAND MEDICALLY NECESSARY PA REQUEST.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0696	01/01/1900	COMPOUND CLAIM AND MISSING OR INVALID ROUTE OF ADMINISTRATION
0697	01/01/1900	THE NUMBER OF TOOTH SURFACES INDICATED IS INSUFFICIENT FOR THE PROCEDURE CODE BILLED.
0698	01/01/1900	MEMBER IS NOT ENROLLED FOR THE DATE(S) OF SERVICE.
0699	01/01/1900	INGREDIENT COST OF THIS 340B DRUG MUST BE SUBMITTED
0700	01/01/1900	DIAGNOSIS TREATMENT INDICATOR IS INVALID.
0701	09/01/2020	SCC INVALID FOR DOUBLE DOSE AND BOOSTER COVID VACCINES.
0702	09/01/2020	VACCINES REQUIRE PROFESSIONAL SERVICE CODE MA
0703	01/01/1900	INCENTIVE AMOUNT SUBMITTED FOR VACCINE ADMINISTRATION DOES NOT MATCH ALLOWED ADMINISTRATION FEE.
0704	01/01/1900	ADULT NON-COVID VACCINES ARE NOT COVERED FOR LONG TERM CARE (LTC) MEMBERS
0705	01/01/1900	HEALTHCHECK SCREENINGS OR OUTREACH IS LIMITED TO SIX PER YEAR FOR MEMBERS UP TOONE YEAR OF AGE.
0706	01/01/1900	HEALTHCHECK SCREENINGS OR OUTREACH LIMITED TO THREE PER YEAR FOR MEMBERS BETWEEN THE AGE OF ONE AND TWO YEARS.
0707	01/01/1900	HEALTHCHECK SCREENINGS OR OUTREACH LIMITED TO TWO PER YEAR FOR MEMBERS BETWEENTHE AGES OF TWO AND THREE YEARS.
0708	01/01/1900	HEALTHCHECK SCREENINGS/OUTREACH LIMITED TO ONE PER YEAR FOR MEMBERS AGE 3 OR OLDER.
0709	01/01/1900	ONE VISIT ALLOWED PER DAY, SERVICE DENIED AS DUPLICATE.
0710	01/01/1900	MEMBER SPI INDICATOR SET FOR DOS
0711	09/01/2020	COVID VACCINE SUBMITTED WITH PROFESSIONAL SERVICE CODE MA
0712	01/01/1900	THE CLAIM SUBMITTED IS OUTSIDE THE ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM.
0716	01/01/1900	THE VALUE CODE AND/OR VALUE CODE AMOUNT IS MISSING, INVALID OR INCORRECT.
0718	01/01/1900	REFERRING PROVIDER NUMBER MISSING OR INVALID
0719	01/01/1900	ADMISSION DATE DOES NOT MATCH THE HEADER FROM DATE OF SERVICE.
0720	01/01/1900	BILLING PROVIDER IS NOT CERTIFIED FOR THE DATE(S) OF SERVICE.
0721	01/01/1900	INVALID USE OF BILATERAL PROCEDURE MODIFIER
0722	01/01/1900	Invalid use of Multiple Procedure Modifier (51)
0723	01/01/1900	INVALID USE OF THE TWO SURGEONS MODIFIER (62)
0725	01/01/1900	OUTPATIENT DATE BUNDLING NOT ALLOWED
0726	01/01/1900	OUTPATIENT DATE BUNDLING LIMIT EXCEEDED
0730	01/01/1900	ONLY THE INITIAL BASE RATE IS PAYABLE WHEN WAITING TIME IS BILLED IN CONJUNCTION WITH A ROUND TRIP.
0733	01/01/1900	DAY TREATMENT EXCEEDING 120 HOURS PER MONTH IS NOT PAYABLE REGARDLESS OF PRIORAUTHORZATION
0737	01/01/1900	PAID IN ACCORDANCE WITH DENTAL POLICY GUIDE DETERMINED BY DHS.
0745	01/01/1900	REIMBURSEMENT FOR MYCOTIC PROCEDURES IS LIMITED TO SIX DATES OF SERVICE PER CALENDAR YEAR.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0746	01/01/1900	ROUTINE FOOT CARE IS LIMITED TO NO MORE THAN ONCE EVERY 61DAYS PER MEMBER.
0749	01/01/1900	ROUTINE FOOT CARE DIAGNOSES MUST BE BILLED WITH VALID ROUTINE FOOT CARE PROCEDURE CODES.
0752	01/01/1900	INPATIENT ADMISSION LESS THAN 24 HOURS, REBILL AS OUTPATIENT
0770	01/01/1900	THE REVENUE CODE IS NOT ALLOWED FOR THE TYPE OF BILL INDICATED ON THE CLAIM.
0771	01/01/1900	MEMBER HAS MEDICARE MANAGED CARE FOR THE DATE(S) OF SERVICE. THE SERVICE BILLED IS ONLY COVERED IF PROVIDED BY THAT PLAN.
0776	01/01/1900	THE PROVIDER IS NOT LISTED AS THE MEMBER'S NURSING HOME LEVEL OF CARE PROVIDERFOR THESE DATES OF SERVICE.
0780	01/01/1900	HAC NEVER EVENT MOD PRESENT
0784	01/01/1900	DENIED/CUTBACK. ONLY ONE INITIAL VISIT OF EACH DISCIPLINE (NURSING) IS ALLOWEDPER DAY PER MEMBER.
0789	01/01/1900	DENTAL SERVICE LIMITED TO TWICE IN A SIX MONTH PERIOD.
0790	01/01/1900	BILLING PROVIDER MAY ONLY BILL EYEGLASS SERVICES
0794	01/01/1900	PROCEDURE NOT ALLOWED FOR THE CLIA CERTIFICATION TYPE.
0795	01/01/1900	COMPLEX EVALUATION AND MANAGEMENT PROCEDURES REQUIRE HISTORY AND PHYSICAL OR MEDICAL PROGRESS REPORT TO BE SUBMITTED WITH THE CLAIM.
0798	01/01/1900	TPL-PAYMENT IS LESS THAN PERCENTAGE SPECIFIED ON SYSTEM PARAMETER
0801	01/01/1900	ONE OR MORE DIAGNOSIS CODES ARE NOT APPLICABLE TO THE MEMBER'S GENDER.
0806	01/01/1900	EXTERNAL CAUSE OF MORBIDITY DIAGNOSIS CODE(S) ARE INVALID AS THE ADMITTING/PRINCIPAL DIAGNOSIS 1.
0807	01/01/1900	DIAGNOSIS CODE INDICATED IS NOT VALID AS A PRIMARY DIAGNOSIS.
0808	01/01/1900	SECONDARY DIAGNOSIS CODE(S) IN POSITIONS 2-9 CANNOT DUPLICATE THE PRIMARY DISCHARGE DIAGNOSIS.
0809	01/01/1900	THIS CLAIM MUST CONTAIN AT LEAST ONE SPECIFIED ICD PROCEDURE CODE. A CLAIM CANNOT CONTAIN ONLY NOT OTHERWISE SPECIFIED (NOS) ICD PROCEDURE CODES.
0810	01/01/1900	A COVERED DRG CANNOT BE ASSIGNED TO THE CLAIM. THE INFORMATION ON THE CLAIM ISINVALID OR NOT SPECIFIC ENOUGH TO ASSIGN A DRG.
0811	01/01/1900	RELATIVE WEIGHT NOT ON FILE.
0812	01/01/1900	DENIED/CUTBACK. REIMBURSEMENT LIMIT FOR ALL ADJUNCTIVE EMERGENCY SERVICES IS EXCEEDED.
0813	01/01/1900	CLAIM REIMBURSEMENT HAS BEEN CUTBACK TO REIMBURSEMENT LIMITS FOR SERVICES PERFORMED.
0814	01/01/1900	SERVICE NOT COVERED AS DETERMINED BY A MEDICAL CONSULTANT
0815	01/01/1900	DENIED/CUTBACK. HOME HEALTH VISITS (NURSING AND THERAPY) IN EXCESS OF 30 VISITSPER CALENDAR YEAR PER MEMBER REQUIRE PRIOR AUTHORIZATION.
0816	01/01/1900	DENIED/CUTBACK. THERAPY VISITS IN EXCESS OF ONE PER DAY PER DISCIPLINE PER MEMBER ARE NOT REIMBURSABLE.
0819	01/01/1900	DENIED/CUTBACK. LIMITED TO ONCE PER QUADRANT PER DAY.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0824	01/01/1900	PROCEDURE CODE IS NOT COVERED FOR MEMBERS WITH A NURSING HOME AUTHORIZATION ONTHE DATE(S) OF SERVICE.
0825	01/01/1900	CASE PLAN AND/OR ASSESSMENT REIMBURSMENT IS LIMITED TO ONE PER CALENDAR YEAR.CALENDAR YEAR.
0826	01/01/1900	SERVICE IS REIMBURSABLE ONLY ONCE PER CALENDAR MONTH.
0829	01/01/1900	TIMELY FILING DEADLINE EXCEEDED.
0832	01/01/1900	ORTHOSIS ADDITIONS IS LIMITED TO TWO PER ORTHOSIS WITHIN THE TWO YEAR LIFE EXPECTANCY OF THE ITEM WITHOUT PRIOR AUTHORIZATION.
0834	01/01/1900	CRITICAL CARE PERFORMED IN AIR AMBULANCE REQUIRES MEDICAL NECESSITY DOCUMENTATION WITH THE CLAIM. CRITICAL CARE IN NON-AIR AMBULANCE IS NOT COVERED.
0836	01/01/1900	FOR REVENUE CODE 0820, 0821, 0825 OR 0829, HCPCS CODE 90999 OR MODIFIER G1-G6 MUST BE PRESENT.
0839	01/01/1900	HOME CARE ONGOING ASSESSMENTS ARE ALLOWED ONCE EVERY SIXTY DAYS PER MEMBER.NT, BUT AREPAYABLE EVERY FIFTY-FOURTH DAY FOR FLEXIBILITY IN SCHEDULING.
0840	01/01/1900	THE TIMELY FILING DEADLINE WAS EXCEEDED. PLEASE RESUBMIT VIA WEB PORTAL OR PAPER WITH DOCUMENTATION.
0841	01/01/1900	THE TIMELY FILING DEADLINE WAS EXCEEDED.
0842	01/01/1900	REFER TO THE PDL. THE REQUESTED DRUG DOES NOT MEET THE AGE LIMIT. REQUIRES AN AGE WAIVER SIGNED BY THE PRESCRIBER FOR APPROVAL.
0843	01/01/1900	THREE FIELDS REQUIRED FOR DUR OVERRIDE.
0844	01/01/1900	PERSONAL CARE SUBSEQUENT AND/OR FOLLOW UP VISITS LIMITED TO SEVEN PER DATE OF SERVICE PER MEMBER.
0852	01/01/1900	NDC REQUIRES WHOLE NUMBER FOR QTY BILLED
0853	01/01/1900	DISPENSE DATE OF SERVICE IS REQUIRED.
0858	01/01/1900	THE REVENUE ACCOMODATION BILLING CODE ON THE CLAIM DOES NOT MATCH THE REVENUE ACCOMODATION BILLING CODE ON THE MEMBER FILE OR DOES NOT MATCH FOR THESE DATES OF SERVICE.
0859	01/01/1900	MODIFIERS SUBMITTED ARE INVALID FOR THE DATE OF SERVICE OR ARE MISSING.
0860	01/01/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE SIXTH DIAGNOSIS CODE.
0861	01/01/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE SEVENTH DIAGNOSISCODE.
0862	01/01/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE EIGHTH DIAGNOSIS CODE.
0863	01/01/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE NINTH DIAGNOSIS CODE.
0868	01/01/1900	DENIED. ELECTION FORM IS NOT ON FILE FOR THIS MEMBER. RESUBMIT CLAIM ONCE ELECTION FORM REQUIREMENTS ARE MET PER THE HOSPICE PROVIDER HANDBOOK.
0876	01/01/1900	CHILD CARE COORDINATION SERVICES ARE REIMBURSABLE ONLY IF BOTH THE MEMBER AND PROVIDER ARE LOCATED IN MILWAUKEE COUNTY.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0901	01/01/1900	THE FROM DATE OF SERVICE AND TO DATE OF SERVICE MUST BE IN THE SAME CALENDAR MONTH AND YEAR.
0904	01/01/1900	Occurrence Code Group Not Found
0918	01/01/1900	MEDICARE DISCLAIMER CODE INVALID. MEMBER IS NOT MEDICARE ENROLLED AND/OR PROVIDER IS NOT MEDICARE CERTIFIED.
0919	01/01/1900	BILLING PROVIDER DOES NOT HAVE REQUIRED CERTIFICATION ADDENDUM ON FILE.
0920	01/01/1900	OTHER COVERAGE CODE IS NOT ALLOWED.
0922	01/01/1900	DUPLICATE COMPOUND INGREDIENT BILLED.
0923	01/01/1900	REIMBURSEMENT FOR THIS PROCEDURE AND A RELATED PROCEDURE IS LIMITED TO ONCE PERDATE OF SERVICE.
0925	01/01/1900	THIS PROCEDURE IS LIMITED TO ONCE PER DAY.
0931	01/01/1900	CONDITION CODE IS MISSING/INVALID OR INCORRECT FOR THE PROCEDURE OR REVENUE CODE SUBMITTED.
0933	01/01/1900	SERVICE IS COVERED ONLY DURING THE FIRST MONTH OF ENROLLMENT IN THE HOME AND COMMUNITY BASED WAIVER.
0935	01/01/1900	INVALID BILLING OF PROCEDURE CODE.
0937	01/01/1900	THIS CLAIM IS BEING DENIED BECAUSE IT IS AN EXACT DUPLICATE OF CLAIM SUBMITTED.
0939	01/01/1900	X12 OR NCPDP VERSION IS INVALID
0940	01/01/1900	DME RENTAL IS LIMITED TO 15 MONTHS WITHOUT PRIOR AUTHORIZATION.
0941	01/01/1900	THIS UNBUNDLED PROCEDURE CODE AND BILLED CHARGE WERE REBUNDLED TO ANOTHER CODE,WHICH WAS EITHER BILLED BY THE PROVIDER ON THIS CLAIM OR ADDED BY CLAIMCHECK.
0942	01/01/1900	THIS PROCEDURE CODE IS DENIED AS MUTUALLY EXCLUSIVE TO ANOTHER CODE BILLED ON THIS CLAIM.
0943	01/01/1900	THIS PROCEDURE CODE IS DENIED AS INCIDENTAL/INTEGRAL TO ANOTHER PROCEDURE CODEBILLED ON THIS CLAIM.
0944	01/01/1900	QUANTITY BILLED IS NOT EQUALLY DIVISIBLE BY THE NUMBER OF DATES OF SERVICE ON THE DETAIL.
0945	01/01/1900	SERVICES ON THIS CLAIM HAVE BEEN SPLIT TO FACILITATE PROCESSING.ON ON YOUR PART IS REQUIRED.
0946	01/01/1900	CLAIM REVIEWED BY PHARMACY CONSULTANT
0947	01/01/1900	CLAIM REVIEWED BY DOM PHARMACY CONSULTANT
0948	01/01/1900	CLAIM REVIEWED BY MEDICAL CONSULTANT
0949	01/01/1900	CLAIM REVIEWED BY DOM MEDICAL CONSULTANT
0957	01/01/1900	OTHER PAYER COVERAGE TYPE NOT ALLOWED.
0958	01/01/1900	DENIED. PLEASE RESUBMIT THIS CLAIM WITH THE INSURANCE EOB SHOWING A DENIAL OR PARTIAL PAYMENT.
0959	01/01/1900	DENIED. THE INSURANCE EOB DOES NOT CORRESPOND TO THE DATES OF SERVICE/SERVICESBEING BILLED.
0961	01/01/1900	SPEECH THERAPY LIMITED TO 35 TREATMENT DAYS PER LIFETIME WITHOUT PRIOR AUTHORIZATION.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0962	01/01/1900	CLAIM INDICATES OTHER INSURANCE COVERAGE BUT THE MEMBER DOES NOT HAVE COMMERCIAL INSURANCE FOR THE DATE(S) OF SERVICE ON FILE
0963	01/01/1900	PHYSICAL THERAPY LIMITED TO 35 TREATMENT DAYS PER LIFETIME WITHOUT PRIOR AUTHORIZATION.
0965	01/01/1900	OCCUPATIONAL THERAPY LIMITED TO 35 TREATMENT DAYS PER LIFETIME WITHOUT PRIOR AUTHORIZATION.
0970	01/01/1900	MORE THAN 50 HOURS OF PERSONAL CARE SERVICES PER CALENDAR YEAR REQUIRE PRIOR AUTHORIZATION.
0974	01/01/1900	DENIED. PROVIDERS MAY ONLY BILL FOR ASSESSMENTS AND CARE PLANS TWICE PER CALENDAR YEAR.
0979	01/01/1900	PHARMACEUTICAL CARE ALLOWED WITH PAYABLE NDC OR IF RX NOT FILLED A QTY OF ZERO.
0987	01/01/1900	SURGICAL PROCEDURE CODE IS NOT RELATED TO PRINCIPAL DIAGNOSIS CODE. DRG CANNOTBE DETERMINED. REIMBURSEMENT DETERMINATION HAS BEEN MADE UNDER DRG 981, 982, OR 983. RECODING/ADJUSTING CLAIM MAY RESULT IN A DIFFERENT DRG CODE ASSIGNMENTAND REIMBURSEMENT.
0989	01/01/1900	CLAIM DENIED. ATTACHMENT WAS NOT RECEIVED WITHIN 21 DAYS OF A CLAIM RECEIPT.
0992	01/01/1900	DENIED/CUTBACK. THE DISPOSABLE MEDICAL SUPPLY PROCEDURE CODE HAS A CONTRACTED MAX QUANTITY LIMIT. PRIOR AUTHORIZATION IS REQUIRED TO EXCEED THIS LIMIT.
0994	01/01/1900	COMPOUND REQUIRES 2 OR MORE INGREDIENTS.
0996	01/01/1900	PHARMACEUTICAL CARE LIMIT EXCEEDED.
0999	01/01/1900	RURAL HEALTH CLINICS MAY ONLY BILL REVENUE CODES ON MEDICARE CROSSOVER CLAIMS
1000	01/01/1900	CLAIM PENDED FOR EXAMINER REVIEW
1001	01/01/1900	COB- BENEFIT PLAN
1002	01/01/1900	COB - PAYER
1003	01/01/1900	SERVICE DENIED BECAUSE SIGNFICANT CONTINOUS STAY SERVICE WAS DENIED.
1004	01/01/1900	MULTIPLE SIGNIFICANT CONTINUOUS STAY SERVICES BILLED ON THE SAME CLAIM AND AT LEAST ONE SIGNIFICANT SERVICE MAY DENY.
1005	01/01/1900	THE ELIGIBILITY OF THE MEMBER DOES NOT FALL WITHIN THE DEPARTMENT OF CORRECTIONRESTRICTION.
1009	01/01/1900	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
1011	01/01/1900	CONTRACT COULD NOT BE DETERMINDED
1012	01/01/1900	MORE THAN ONE VISIT DONE ON THE SAME DAY BY THE SAME BILLING PROVIDER REQUIRESADDITIONAL DOCUMENTATION. RESUBMIT WITH OFFICE OR HOME VISIT NOTES FOR ALL VISITS.
1013	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM PREVIOUSLY SUBMITTED. ADJUST AS NECESSARY.
1015	01/01/1900	PAYMENT HAS BEEN MADE TO ANOTHER PROVIDER FOR THIS SERVICE FOR THE SAME DATE.VERIFY YOUR BILLING, CORRECT AND RESUBMIT, OR RESUBMIT WITH DOCUMENTATION.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1017	01/01/1900	YOU ARE BILLING 80051 AND 80053. ALL OF THE COMPONENTS OF 80051 ARE INCLUDED IN80053. IF THE PANELS ARE RUN ON SEPARATE SPECIMENS, RESUBMIT WITH DOCUMENTATION FOR BOTH PANELS.
1019	01/01/1900	PAYMENT HAS ALREADY BEEN MADE TO THE PERFORMING PROVIDER UNDER A DIFFERENT BILLING PROVIDER NUMBER. REVIEW. IF CORRECT, RESUBMIT WITH DOCUMENTATION FOR BOTHSERVICES.
1020	01/01/1900	ALL OR PART OF THIS CLAIM IS A DUPLICATE OF A CROSSOVER CLAIM WHICH HAS ALREADYBEEN PAID.
1021	01/01/1900	YOU ARE BILLING 80048 AND 80069. ALL OF THE COMPONENTS OF 80048 ARE INCLUDED IN80069. IF THE PANELS ARE RUN ON SEPARATE SPECIMENS, RESUBMIT WITH DOCUMENTATION FOR BOTH PANELS.
1022	01/01/1900	YOU OR ANOTHER PROVIDER HAVE BILLED FOR A COMPREHENSIVE ORAL EXAM WITHIN TWO YEARS. IF CORRECT, RESUBMIT WITH EXPLANATION.
1023	01/01/1900	ANOTHER PROVIDER WITHIN YOUR GROUP HAS BILLED FOR THIS SERVICE FOR THE SAME DATE. CHECK YOUR RECORDS. IF CORRECT, RESUBMIT WITH NOTES TO DOCUMENT BOTH SERVICES.
1024	01/01/1900	RESTORATIONS FOR SAME TOOTH AND SURFACE/S ARE COVERED ONE TIME IN TWO YEARS. RESUBMIT WITH DOCUMENTATION AND NARRATIVE.
1025	01/01/1900	PROCEDURE CODE BILLED REQUIRES AN ARCH.
1026	01/01/1900	MEDICAID COVERS ONE PREVENTIVE MEDICINE SERVICE FOR THE HEALTHY INDIVIDUAL EVERY TWO CALENDAR YEARS FOR AGES 50 THROUGH 59. PAYMENT HAS ALREADY BEEN MADE.
1027	01/01/1900	MEDICAID COVERS ONE PREVENTIVE MEDICINE SERVICE FOR THE HEALTHY INDIVIDUAL EACHCALENDAR YEAR AGES 60 AND OVER. PAYMENT HAS ALREADY BEEN MADE FOR THIS CALENDAR YEAR.
1028	01/01/1900	EXPECTED HEADSTART ENROLLMENT DATE REQUIRED IN ORDER TO CONSIDER INTERPERIODICEVALUATION.
1029	01/01/1900	SERVICE COVERED ONE TIME IN TWO YEARS. YOU OR ANOTHER PROVIDER HAVE BEEN REIMBURSED FOR THIS SERVICE.
1030	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM ALREADY PAID TO YOUR FACILITY FOR OUTPATIENT SERVICES. ADJUST AS NECESSARY.
1031	01/01/1900	YOU ARE BILLING FOR A THERAPY SERVICE FOR A NURSING HOME RESIDENT ONLY THE NURSING HOME CAN BILL MEDICAID FOR THIS SERVICE SUBMIT YOUR BILL TO THE NURSING HOME.
1032	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM ALREADY PAID TO YOUR FACILITY UNDER A DIFFERENT PROVIDER NUMBER.
1033	01/01/1900	YOU ARE BILLING A PROCEDURE WITH TECHNICAL AND PROFESSIONAL COMPONENTS IN A FACILITY. REBILL WITH MODIFIER TC OR SUBMIT DOCUMENTATION THAT YOU PROVIDED THE PROFESSIONAL COMPONENT.
1034	01/01/1900	ANOTHER PROVIDER HAS BILLED FOR THIS SERVICE IN THE LAST 6 MONTHS. RESEND WITHDOCUMENTATION AND NARRATIVE FOR DEFECTIVE RESTORATION.
1035	01/01/1900	RESUBMIT WITH CARIES RISK ASSESSMENT CODE FOR REIMBURSMENT.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1036	01/01/1900	PROCEDURE IS ALLOWED ONE TIME IN 6 MONTHS AFTER COMPLETION OF PERIODONTAL SCALING. MUST NOT BE BILLED WITHIN 3 MONTHS OF PROPHYLAXIS.
1037	01/01/1900	YOU OR ANOTHER PROVIDER HAVE BILLED FOR AN EXTENSIVE ORAL EVALUATION FOR ANOTHER DATE OF SERVICE WITHIN 1 YEAR. RESUBMIT WITH NARRATIVE AND/OR CARIES RISK ASSESSMENT.
1038	01/01/1900	RESUBMIT WITH ACTUAL TEST RESULTS TO DOCUMENT THE LABORATORY SERVICE BILLED.
1039	01/01/1900	YOU ARE BILLING FOR MULTIPLE SURGICAL PROCEDURES ON THE SAME DAY. AN OPERATIVEREPORT IS REQUIRED IN ORDER TO DETERMINE THE PROPER PAYMENT.
1040	01/01/1900	YOU ARE BILLING 80048 AND 80053. ALL OF THE COMPONENTS OF 80048 ARE INCLUDED IN80053. IF THE PANELS ARE RUN ON SEPARATE SPECIMENS, RESUBMIT WITH DOCUMENTATION FOR BOTH PANELS.
1041	01/01/1900	YOU ARE BILLING MULTIPLE URINALYSIS CODES W/SAME DOS.IF MULTIPLE TESTS ON SAMESPECIMEN,BILL CODE THAT DESCRIBES COMPLETE TEST.IF SEPARATE SPECIMENS, RESUBMITW/BOTH TEST RESULTS.
1043	01/01/1900	YOU HAVE ALREADY BEEN PAID FOR A PANEL. ALL COMPONENTS OF PAID PANEL ARE INCLUDED IN THIS PANEL. ADJUST PREVIOUSLY PAID PANEL OR RESUBMIT WITH DOCUMENTATION FOR BOTH PANELS.
1046	01/01/1900	YOU HAVE BILLED FOR PERIODIC OR COMPREHENSIVE DENTAL EXAM FOR ANOTHER DATE OFSERVICE WITHIN 6 MONTHS. IF ADD'L EXAM MEDICALLY NECESSARY, SUBMIT REQUEST FORPRIOR AUTHORIZATION.
1047	01/01/1900	THE DATES OF SERVICE ON YOUR CLAIM OVERLAP THE DATES OF SERVICE ON AN INPATIENTHOSPITAL CLAIM. REVIEW THE DATES OF SERVICE ON YOUR CLAIM. CALL HPES PROVIDERSERVICES WITH QUESTIONS.
1049	01/01/1900	YOU ARE BILLING 80051 AND 80048. ALL OF THE COMPONENTS OF 80051 ARE INCLUDED IN80048. IF THE PANELS ARE RUN ON SEPARATE SPECIMENS, RESUBMIT WITH DOCUMENTATION FOR BOTH PANELS.
1050	01/01/1900	MEDICARE COINSURANCE OR PAYMENT IS NOT WITHIN AN ALLOWABLE RANGE.
1052	01/01/1900	YOU HAVE ALREADY BEEN PAID FOR THE EXTRACTION OF THIS TOOTH FOR ANOTHER DATE OFSERVICE
1053	01/01/1900	ONE NEW PATIENT SERVICE PER 3 YEARS PER PROVIDER
1056	01/01/1900	THIS PROCEDURE REQUIRES BILLING EACH DATE OF SERVICE ON A SEPARATE DETAIL WITHTHE ASSOCIATED NUMBER OF UNITS FOR THAT DAY.
1057	01/01/1900	PLEASE RESUBMIT WITH DOCUMENTATION FROM OFFICE, OUTPATIENT, OR HOSPITAL SERVICEBEING BILLED.
1058	01/01/1900	MORE THAN ONE VISIT DONE ON THE SAME DAY BY THE SAME BILLING PROVIDER REQUIRESADDITIONAL DOCUMENTATION. RESUBMIT WITH OFFICE OR HOME VISIT NOTES FOR ALL VISITS.
1059	01/01/1900	YOU ARE BILLING A HOSPITAL READMISSION WITHIN 10 DAYS OF INITIAL DISCHARGE. RESUBMIT WITH DISCHARGE SUMMARY FOR BOTH ADMISSIONS.
1060	01/01/1900	YOU ARE BILLING A HOSPITAL READMISSION WITHIN 10 DAYS OF INITIAL DISCHARGE. BASED ON REVIEW OF DOCUMENTATION SUBMITTED, THIS CLAIM WILL NOT BE PAID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1061	01/01/1900	DOCUMENTATION DOES NOT SUPPORT REIMBURSMENT FOR ADDITIONAL RESTORATION.
1062	01/01/1900	PHOTOGRAPHS ARE ONLY ALLOWED ONE TIME IN 6 MONTHS WHEN REQUESTED FOR DENTAL REVIEW.
1063	01/01/1900	PHOTOGRAPHS ARE ONLY ALLOWED TO BE BILLED FOR INTERCEPTIVE OR LIMITED ORTHODONTICS ONE TIME.
1064	01/01/1900	MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS ARE ZERO
1065	01/01/1900	YOU ARE BILLING A MICROSCOPIC EVALUATION PROCEDURE ON THE SAME DATE AS A CBC. RESUBMIT WITH TEST RESULTS FOR THE CBC THAT DOCUMENT MEDICAL NECESSITY OF THE MICROSCOPIC EVALUATION.
1066	01/01/1900	YOU ARE USING INDIVIDUAL HCPCS PROCEDURE CODES WHEN THERE IS A VALID CODE THATCOMBINES SERVICES RENDERED. REVIEW THE HCPCS PROCEDURE CODES AND RESUBMIT AND/OR ADJUST.
1067	01/01/1900	YOU HAVE BEEN PAID FOR AN INDIVIDUAL COMPONENT OF THIS TEST FOR THIS DATE OF SERVICE. REVIEW PROVIDER MANUAL. ADJUST PAID CLAIM OR RESUBMIT WITH DOCUMENTATIONFOR BOTH SERVICES.
1068	01/01/1900	YOU ARE BILLING MULTIPLE CODES FOR BLOOD COUNT AND/OR PLATELET COUNT. IF THE SAME SPECIMEN IS USED, BILL THE SINGLE CODE THAT ACCURATELY DESCRIBES ALL COMPONENTS.
1069	01/01/1900	YOU ARE BILLING INDIVIDUAL COMPONENT ON SAME DAY AS PANEL. REVIEW PROVIDER MANUAL. IF ADD'L TESTING PERFORMED, RESUBMIT WITH ACTUAL TEST RESULTS FOR BOTH PANEL AND COMPONENT.
1070	01/01/1900	RESUBMIT WITH THE PHYSICIAN'S ORDER AND THE REPORT OF LAB RESULTS TO JUSTIFY SERVICES AS BILLED.
1071	01/01/1900	YOU ARE BILLING 80053 AND 80076. SIX OF THE COMPONENTS OF 80076 ARE INCLUDED IN80053. IF THE PANELS ARE RUN ON SEPARATE SPECIMENS, RESUBMIT WITH DOCUMENTATION FOR BOTH PANELS.
1072	01/01/1900	YOU ARE BILLING 80053 AND 80069. NINE OF THE COMPONENTS OF 80069 ARE INCLUDED IN 80053. IF PANELS ARE RUN ON SEPARATE SPECIMENS, RESUBMIT WITH DOCUMENTATIONFOR BOTH PANELS.
1073	01/01/1900	PROCEDURE CODE BILLED IS EITHER CONSIDERED PART OF ANOTHER SERVICE, PAYABLE ONLY UNDER ANOTHER PROCEDURE CODE, OR NOT COVERED BY DELAWARE MEDICAID. SEE PROVIDER MANUAL OR CALL HPES.
1075	01/01/1900	YOU ARE BILLING MORE THAN 7 DAYS OF LEAVE OF ABSENCE IN ONE CALENDAR MONTH. CALL HPES PROVIDER SERVICES WITH QUESTIONS.
1076	01/01/1900	PROV CONTRACT NOT VALID ON DOS - DTL
1077	01/01/1900	RENDERING PROVIDER TAXONOMY NOT VALID FOR PROCEDURE CODE
1078	01/01/1900	MENTAL HEALTH SERVICES FOR THIS CLIENT MUST BE APPROVED BY AND BILLED TO THE DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH. CONTACT THE ELIGIBILITY/ENROLLMENTUNIT AT 302 255-9460
1079	01/01/1900	THE PROCEDURE ON THE CLAIM APPEARS TO BE A REQUIRED FOR PALLIATIVE TREATMENT.
1080	01/01/1900	PALLIATIVE TREATMENT BILLED ON SAME DAY, FOR THE SAME TOOTH, BY THE SAME PROVIDER, WITH PROCEDURE FOR ROOT CANAL NOT ALLOWED.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1081	01/01/1900	THE HCPCS PROCEDURE CODE BILLED IS INCLUDED IN THE DESCRIPTION OF THE PRIMARY PROCEDURE.
1082	01/01/1900	THIS SERVICE IS NOT PAYABLE WITH ANOTHER SERVICE ON THE SAME DATE OF SERVICE DUE TO NATIONAL CORRECT CODING INITIATIVE.
1083	01/01/1900	A PREVIOUSLY PAID SERVICE IS BEING RECOUPED PER NATIONAL CORRECT CODING INITIATIVE (NCCI) PROCESSING OF ANOTHER SERVICE ON THE SAME DATE OF SERVICE BY THE SAME PROVIDER.
1084	01/01/1900	CLAIM SUSPENDED BECAUSE AN ATTACHMENT WAS INDICATED, BUT NOT RECEIVED. CLAIM WILL SUSPEND FOR UP TO 21 DAYS, UNTIL ATTACHMENT IS RECEIVED, OR AFTER 21 DAYS YOUR CLAIM WILL DENY.
1085	01/01/1900	PROVIDER IS A FACILITY OR GROUP PROVIDER. A RENDERING PROVIDER IS REQUIRED.
1086	01/01/1900	FORCE DENY-USER
1087	01/01/1900	SERVICES NOT COVERED FOR TOOTH THAT HAS PREVIOUSLY BEEN EXTRACTED
1088	01/01/1900	SERVICE LIMITED TO ONE PER DAY
1089	01/01/1900	SERVICE LIMITED TO ONE EVERY 160 DAYS
1090	01/01/1900	SERVICE LIMITED TO ONE PER DAY PER RENDERING PROVIDER
1091	01/01/1900	SERVICE LIMITED TO ONE PER DAY, PER RENDERING PROVIDER PER TOOTH
1092	01/01/1900	SERVICE LIMITED TO ONE PER DAY, PER PROVIDER PER TOOTH
1093	01/01/1900	SERVICE LIMITED TO ONE EVERY 345 DAYS, PER PROVIDER
1094	01/01/1900	SERVICE LIMITED TO ONE EVERY 5 YEARS, PER PROVDER, PER TOOTH
1095	01/01/1900	SERVICE LIMITED TO ONE PER LIFETIME, PER TOOTH
1096	01/01/1900	SERVICE LIMITED TO ONE PER LIFETIME, PER TOOTH
1097	01/01/1900	MEMBER HAS EXCEEDED $1000 SERVICE LIMIT
1098	01/01/1900	SERVICE LIMITED TO ONE EVERY 10 DAYS
1099	01/01/1900	One LTC Speech Therapy eval per year
1100	01/01/1900	THE AMOUNT IN THE OTHER INSURANCE FIELD IS INVALID.
1101	01/01/1900	QUANTITY BILLED IS INVALID.
1102	01/01/1900	THE ADMIT DATE IS INVALID.
1103	01/01/1900	THE NUMBER OF COVERED DAYS IS REQUIRED.
1104	01/01/1900	A NUMBER IS REQUIRED IN THE COVERED DAYS FIELD.
1105	01/01/1900	ONE OR MORE OCCURRENCE CODE DATE(S) IS INVALID IN POSITIONS NINE THROUGH 24.
1106	01/01/1900	INTERIM BILLING CRITERIA NOT MET.
1107	01/01/1900	ADMIT DATE AND FROM DATE OF SERVICE MUST MATCH.
1108	01/01/1900	GROSS AMOUNT DUE AND/OR U&C REQUIRED.
1109	01/01/1900	RENDERING PROVIDER IS NOT A CERTIFIED PROVIDER.
1112	01/01/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE RENDERING PROVIDER LISTED IN THE HEADER.
1113	01/01/1900	SERVICES ARE NOT PAYABLE. MEMBER IS ON REVIEW.
1116	01/01/1900	THE REVENUE CODE REQUIRES AN APPROPRIATE CORRESPONDING PROCEDURE CODE.
1117	01/01/1900	THE NATIONAL DRUG CODE (NDC) HAS AN AGE RESTRICTION.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1118	01/01/1900	THE NATIONAL DRUG CODE (NDC) HAS A QUANTITY RESTRICTION.
1119	01/01/1900	ONE OR MORE DIAGNOSIS CODES HAS AN AGE RESTRICTION.
1120	01/01/1900	ONE OR MORE DIAGNOSIS CODES HAS A GENDER RESTRICTION.
1121	01/01/1900	MEMBER DOES NOT MEET THE AGE RESTRICTION FOR THIS PROCEDURE CODE.
1122	01/01/1900	FAMILY PLANNING FUNDING 90% .
1123	01/01/1900	FAMILY PLANNING FUNDING REGULAR MATCH
1124	01/01/1900	FAMILY PLANNING FUNDING ERROR
1125	01/01/1900	NO FEDERAL DRUG REBATE AGREEMENT.
1126	01/01/1900	SECOND MODIFIER CODE IS INVALID FOR DATE OF SERVICE.
1127	01/01/1900	THIRD MODIFIER CODE IS INVALID FOR DATE OF SERVICE.
1128	01/01/1900	A TOOTH NUMBER OR LETTER IS REQUIRED.
1129	01/01/1900	OCCURRENCE CODE IS REQUIRED WHEN AN OCCURRENCE DATE IS PRESENT.
1130	01/01/1900	ONE OR MORE CONDITION CODE(S) IS INVALID IN POSITIONS EIGHT THROUGH 24.
1131	01/01/1900	THE PRIMARY OCCURRENCE CODE IS INVALID.
1132	01/01/1900	A PRIMARY OCCURRENCE CODE DATE IS REQUIRED.
1133	01/01/1900	PRINCIPAL SURGICAL CODE DATE IS INVALID.
1134	01/01/1900	FIRST OCCURRENCE SPAN CODE IS INVALID.
1135	01/01/1900	ONE OR MORE FROM DATE(S) OF SERVICE IS INVALID FOR OCCURRENCE SPAN CODES IN POSITIONS THREE THROUGH 24.
1136	01/01/1900	THE AREA OF THE ORAL CAVITY IS INVALID.
1137	01/01/1900	VALUE CODE IS INVALID.
1138	01/01/1900	VALUE CODE AMOUNT IS INVALID.
1139	01/01/1900	HEADER FROM DATE OF SERVICE IS AFTER THE DATE OF RECEIPT OF THE CLAIM.
1140	01/01/1900	NO WCDP DRUG REBATE AGREEMENT.
1141	01/01/1900	MEMBER ENROLLED IN MEDICARE PART D. PDP PAYMENT/DENIAL REQUIRED ON CLAIM.
1142	01/01/1900	THIS MODIFIER HAS BEEN DISCONTINUED BY CMS OR AMA FOR THE DATE OF SERVICE(S).
1143	01/01/1900	ACCOMMODATION CODE(S) IS NOT PAYABLE.
1144	01/01/1900	CMS TERMINATED DRUG.
1145	01/01/1900	AREA OF THE ORAL CAVITY IS REQUIRED FOR PROCEDURE CODE.
1146	01/01/1900	THE SECOND OTHER PROVIDER ID IS MISSING OR INVALID.
1147	01/01/1900	ADMIT DIAGNOSIS CODE IS INVALID.
1148	01/01/1900	SECOND DIAGNOSIS CODE IS INVALID.
1149	01/01/1900	THIRD DIAGNOSIS CODE IS INVALID.
1150	01/01/1900	FOURTH DIAGNOSIS CODE IS INVALID.
1151	01/01/1900	THE FIFTH DIAGNOSIS CODE IS INVALID.
1152	01/01/1900	THE SIXTH DIAGNOSIS CODE IS INVALID.
1153	01/01/1900	THE SEVENTH DIAGNOSIS CODE IS INVALID.
1154	01/01/1900	THE EIGHTH DIAGNOSIS CODE IS INVALID.
1155	01/01/1900	THE NINTH DIAGNOSIS CODE IS INVALID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1156	01/01/1900	PRIMARY DIAGNOSIS CODE IS INVALID.
1157	01/01/1900	ONE OR MORE DIAGNOSIS CODE(S) IS INVALID IN POSITIONS 10 THROUGH 25.
1158	01/01/1900	PRIMARY DIAGNOSIS CODE IS REQUIRED.
1159	01/01/1900	ONE OR MORE DIAGNOSIS CODE(S) IS INVALID FOR THE DATE(S) OF SERVICE.
1160	01/01/1900	PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
1161	01/01/1900	SECONDARY DIAGNOSIS CODE IS NOT ON FILE.
1162	01/01/1900	THIRD DIAGNOSIS CODE IS NOT ON FILE.
1163	01/01/1900	FOURTH DIAGNOSIS CODE IS NOT ON FILE.
1164	01/01/1900	FIFTH DIAGNOSIS CODE IS NOT ON FILE.
1165	01/01/1900	SIXTH DIAGNOSIS CODE IS NOT ON FILE.
1166	01/01/1900	SEVENTH DIAGNOSIS CODE IS NOT ON FILE.
1167	01/01/1900	EIGHTH DIAGNOSIS CODE IS NOT ON FILE.
1168	01/01/1900	NINTH DIAGNOSIS CODE IS NOT ON FILE.
1169	01/01/1900	ONE OR MORE DIAGNOSIS CODE(S) IN POSITIONS 10 THROUGH 25 IS NOT ON FILE.
1170	01/01/1900	TENTH DIAGNOSIS IS INVALID.
1171	01/01/1900	ELEVENTH DIAGNOSIS IS INVALID.
1172	01/01/1900	TWELFTH DIAGNOSIS IS INVALID
1173	01/01/1900	TENTH DIAGNOSIS IS NOT ON FILE.
1174	01/01/1900	THE PROCEDURE CODE IS NOT REIMBURSABLE FOR A FAMILY PLANNING WAIVER MEMBER.
1175	01/01/1900	THE PATIENT STATUS CODE IS INVALID OR CONFLICTS WITH TYPE OF BILL (TOB).
1177	01/01/1900	PATIENT LOCATION IS INVALID.
1178	01/01/1900	SERVICE IS NOT REIMBURSABLE FOR DATE(S) OF SERVICE.
1179	01/01/1900	VALID QUANTITY BILLED IS REQUIRED.
1180	01/01/1900	RX DATE AFTER DISPENSE DATE OF SERVICE.
1181	01/01/1900	PRESCRIPTION DATE EXCEEDS ONE YEAR.
1183	01/01/1900	HEADER FROM DATE OF SERVICE IS AFTER THE HEADER TO DATE OF SERVICE.
1184	01/01/1900	THE HEADER AND DETAIL DATE(S) OF SERVICE CONFLICT.
1185	01/01/1900	THE PROCEDURECODE IS NOT COVERED FOR THE DATE(S) OF SERVICE.
1186	01/01/1900	THE PROCEDURE CODE IS NOT COVERED FOR THE REVENUE CODE BILLED FOR THE DATE(S) OF SERVICE.
1187	01/01/1900	THE REVENUE CODE IS NOT PAYABLE FOR THE DATE(S) OF SERVICE.
1190	01/01/1900	ONE OR MORE DIAGNOSIS CODE(S) IS NOT PAYABLE FOR THE DATE OF SERVICE.
1193	01/01/1900	DISPENSE DATE AFTER CLAIM RECEIPT DATE.
1194	01/01/1900	BILLED AMOUNT IS NOT EQUALLY DIVISIBLE BY THE NUMBER OF DATES OF SERVICE ON THEDETAIL.
1197	01/01/1900	THE PROCEDURE CODE HAS PLACE OF SERVICE RESTRICTIONS.
1198	01/01/1900	A NATIONAL DRUG CODE (NDC) IS REQUIRED FOR THIS HCPCS CODE.
1199	01/01/1900	ONE OR MORE OF THE NDCS SUBMITTED IS NOT RELATED TO THE PROCEDURE CODE BILLED.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1200	01/01/1900	THE NATIONAL DRUG CODE (NDC) SUBMITTED WITH THIS HCPCS CODE IS CMS TERMINATED.
1201	01/01/1900	INVALID QUANTITY FOR THE NATIONAL DRUG CODE (NDC) SUBMITTED WITH THIS HCPCS CODE.
1202	01/01/1900	PRESCRIBER ID IS REQUIRED.
1203	01/01/1900	OUT OF STATE PROVIDER NOT CERTIFIED.
1204	01/01/1900	BILLING PROVIDER IS NOT CERTIFIED FOR THE DATE(S) OF SERVICE.
1205	01/01/1900	OUT OF STATE BILLING PROVIDER NOT ENROLLED FOR ENTIRE DETAIL DOS SPAN.
1207	01/01/1900	A NATIONAL PROVIDER IDENTIFIER (NPI) IS REQUIRED FOR THE BILLING PROVIDER.
1210	01/01/1900	PCN REQUIRED FOR SENIORCARE/WCDP/ADAP.
1211	01/01/1900	THE SURGICAL PROCEDURE CODE HAS DIAGNOSIS RESTRICTIONS.
1212	01/01/1900	NDC HAS ENCOUNTER INDICATOR RESTRICTIONS
1213	01/01/1900	THE PROCEDURE CODE HAS ENCOUNTER INDICATOR RESTRICTIONS.
1214	01/01/1900	THIS REVENUE CODE HAS ENCOUNTER INDICATOR RESTRICTIONS.
1215	01/01/1900	THIS DIAGNOSIS CODE HAS ENCOUNTER INDICATOR RESTRICTIONS.
1216	01/01/1900	THIS SURGICAL CODE HAS ENCOUNTER INDICATOR RESTRICTIONS.
1218	01/01/1900	THE PROCEDURE CODE IS RESTRICTED.
1219	01/01/1900	REVENUE ENCOUNTER BILLING RULE EDIT.
1221	01/01/1900	DIAGNOSIS RESTRICTION ON ICD PROCEDURE COVERAGE RULE.
1222	01/01/1900	CLAIM CANNOT PROCESS BECAUSE THE NURSING HOME MEMBER HAS MULTIPLE NURSING HOMELEVEL OF CARE (LOC) SEGMENTS ON FILE. RESEARCH IS UNDERWAY TO CORRECT OVERLAPPING LOC SEGMENTS.
1224	01/01/1900	PROSPECTIVE DUR ALERT
1225	01/01/1900	DRUG FOR LTC ONLY *NOTE DAY 2- N/A AT THIS TIME
1227	01/01/1900	THE OTHER PAYER ID QUALIFIER IS INVALID.
1228	01/01/1900	THE OTHER PAYER AMOUNT PAID QUALIFIER IS INVALID.
1229	01/01/1900	COMPOUND DRUGS NOT COVERED FOR PROGRAM.
1230	01/01/1900	THE MEDICARE COPAYMENT AMOUNT IS INVALID.
1231	01/01/1900	PRINCIPLE SURGICAL PROCEDURE CODE DATE IS MISSING.
1232	01/01/1900	NON-PREFERRED DRUG IS BEING DISPENSED. PLEASE REFER TO THE PDL FOR PREFERRED DRUGS IN THIS THERAPEUTIC CLASS.
1233	01/01/1900	SUBMISSION CLARIFICATION CODE INVALID.
1234	01/01/1900	NDC NOT COVERED.
1237	01/01/1900	THE BILLING PROVIDER'S TAXONOMY CODE IS INVALID.
1238	01/01/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IN THE HEADER IS INVALID.
1239	01/01/1900	THE PROCEDURE CODE HAS DIAGNOSIS RESTRICTIONS. INITIAL ROUTINE NEWBORN CARE MUST BE BILLED USING 9943, 99432, 99460 OR 99461. SUBSEQUENT HOSPITAL DAYS ARE BILLED UNDER 99433 OR 99462.
1241	01/01/1900	COVERAGE LIMITED TO PREFERRED DRUGS.
1242	01/01/1900	COVERAGE LIMITED TO GENERIC DRUGS.
1243	01/01/1900	COVERAGE LIMITED TO NON-INNOVATOR DRUGS.
1244	01/01/1900	ELEVENTH DIAGNOSIS IS NOT ON FILE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1245	01/01/1900	TWELFTH DIAGNOSIS IS NOT ON FILE.
1246	01/01/1900	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1247	01/01/1900	NOT USED - DMAP OR THE MEMBER CANNOT BE CHARGED SALES TAX.
1248	01/01/1900	TOTAL OTHER PAYER COSTSHARE FOR MEMBER IS REQUIRED.
1249	01/01/1900	ADDITIONAL COSTS ARE NOT COVERED.
1250	01/01/1900	VALID PLACE OF SERVICE IS REQUIRED.
1254	01/01/1900	DME RENTAL BEYOND THE INITIAL 60 DAY PERIOD IS NOT PAYABLE WITHOUT PRIOR AUTHORIZATION.
1255	01/01/1900	DME RENTAL BEYOND THE INITIAL 180 DAY PERIOD IS NOT PAYABLE WITHOUT PRIOR AUTHORIZATION.
1256	01/01/1900	MEMBER IS ENROLLED IN MEDICARE PART A ON THE DATE(S) OF SERVICE.
1257	01/01/1900	MEMBER IS ENROLLED IN MEDICARE PART B ON THE DATE(S) OF SERVICE.
1258	01/01/1900	SERVICE(S) PAID IN ACCORDANCE WITH PROGRAM POLICY LIMITATION.
1259	01/01/1900	HEADER BILLING PROVIDER IS NO LONGER ENROLLED FOR THE DATE OF SERVICE
1260	01/01/1900	THE SUM OF THE ACCOMMODATION DAYS IS NOT EQUAL TO THE HEADER DATE SPAN.
1261	01/01/1900	DETAIL TO DATE OF SERVICE IS INVALID.
1262	01/01/1900	DETAIL TO DATE OF SERVICE IS REQUIRED.
1263	01/01/1900	HEADER AND/OR DETAIL DATES OF SERVICE ARE MISSING, INCORRECT OR CONTAIN FUTUREDATES.
1264	01/01/1900	ADMIT DIAGNOSIS IS REQUIRED.
1265	01/01/1900	THE ADMIT TYPE CODE IS REQUIRED.
1266	01/01/1900	PATIENT STATUS CODE IS INCORRECT FOR LONG TERM CARE CLAIMS.
1267	01/01/1900	THE PATIENT STATUS CODE IS REQUIRED.
1268	01/01/1900	MEDICARE PAID, COINSURANCE, COPAYMENT AND/OR DEDUCTIBLE AMOUNTS DO NOT BALANCE.
1269	01/01/1900	THE SUM OF THE MEDICARE PAID, DEDUCTIBLE(S), COINSURANCE, COPAYMENT AND PSYCHIATRIC REDUCTION AMOUNTS DOES NOT EQUAL THE MEDICARE ALLOWED AMOUNT.
1270	01/01/1900	THE HEADER TOTAL BILLED AMOUNT IS REQUIRED AND MUST BE GREATER THAN ZERO.
1271	01/01/1900	THE TOTAL BILLED AMOUNT IS MISSING OR INCORRECT.
1272	01/01/1900	SUM OF DETAIL BILLED AMOUNTS EXCEED TOTAL BILLED AMOUNT.
1273	01/01/1900	QUANTITY BILLED IS INVALID FOR THE REVENUE CODE.
1275	01/01/1900	QUANTITY BILLED IS RESTRICTED FOR THIS PROCEDURE CODE.
1276	01/01/1900	CLAIM OR ADJUSTMENT RECEIVED BEYOND 730-DAY FILING DEADLINE.
1277	01/01/1900	MEMBER IS NOT ENROLLED FOR THE DISPENSE DATE OF SERVICE.
1278	01/01/1900	PLACE OF SERVICE CODE IS INVALID.
1279	01/01/1900	PROCEDURE NOT PAYABLE FOR PLACE OF SERVICE.
1280	01/01/1900	RENDERING PROVIDER TYPE AND/OR SPECIALTY IS NOT ALLOWABLE FOR THE SERVICE BILLED.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1281	01/01/1900	SURGICAL PROCEDURE CODE BILLED IS NOT APPROPRIATE FOR MEMBER'S GENDER.
1282	01/01/1900	PA REQUIRED FOR PAYMENT OF THIS SERVICE. PROCEDURE CODE AND MODIFIERS BILLED MUST MATCH APPROVED PA.
1283	01/01/1900	PRIOR AUTHORIZATION (PA) REQUIRED FOR PAYMENT OF THIS SERVICE.
1284	01/01/1900	RENDERING PROVIDER IS NOT CERTIFIED FOR THE FROM DATE OF SERVICE.
1285	01/01/1900	THE PRESCRIBER ID IS INVALID.
1286	01/01/1900	DAYS SUPPLY MISSING OR GREATER THAN ALLOWED.
1287	01/01/1900	QUANTITY DISPENSED IS REQUIRED.
1288	01/01/1900	SUBMITTED RENDERING PROVIDER NPI IN THE HEADER IS INVALID.
1289	01/01/1900	TYPE OF BILL INDICATES SERVICES NOT REIMBURSABLE OR FREQUENCY INDICATED IS NOTVALID FOR THE CLAIM TYPE.
1290	01/01/1900	TYPE OF BILL IS INVALID FOR THE CLAIM TYPE.
1291	01/01/1900	VALID SOURCE OF ADMISSION IS REQUIRED.
1293	01/01/1900	IF PRESCRIPTION NUMBER IS MISSING (ZEROS) OR NOT NUMERIC - THEN POST THE ERROR.
1294	01/01/1900	HEADER BILL DATE IS BEFORE THE HEADER FROM DATE OF SERVICE.
1295	01/01/1900	THIS NDC IS INVALID.
1296	01/01/1900	SERVICES BILLED ARE INCLUDED IN THE NURSING HOME RATE STRUCTURE. THESE SERVICESARE NOT BILLABLE FOR DATES OF SERVICE THE MEMBER IS IN A NURSING HOME.
1297	01/01/1900	MEMBER ENROLLED IN COMMERCIAL HEALTH INSURANCE ON DISPENSE DATE.
1298	01/01/1900	MEMBER ID IS NOT ON FILE. BILL USING THE FIRST 9 DIGITS ON THE ID CARD AND NO LEADING ZEROS.
1301	01/01/1900	THIS PROCEDURE IS DUPLICATIVE OF A SERVICE ALREADY BILLED FOR SAME DATE OF SERVICE.
1302	01/01/1900	THIS SERVICE IS DUPLICATIVE OF SERVICE PROVIDED BY ANOTHER PROVIDER FOR THE SAME DATE(S) OF SERVICE.
1303	01/01/1900	PROGRAM GUIDELINES OR COVERAGE WERE EXCEEDED.
1304	01/01/1900	THE DENTAL PROCEDURE CODE AND TOOTH NUMBER COMBINATION IS ALLOWED ONLY ONCE PERLIFETIME.
1305	01/01/1900	THE DENTAL PROCEDURE CODE AND TOOTH NUMBER COMBINATION IS ALLOWED ONLY ONCE PERLIFETIME.
1306	01/01/1900	ADD-ON CODES ARE NOT SEPARATELY REIMBURSEABLE WHEN SUBMITTED AS A STAND-ALONE CODE.
1307	01/01/1900	ENHANCED PAYMENT FOR PROVIDING SERVICES IN A NATURAL ENVIRONMENT IS LIMITED TOONE SERVICE PER DISCIPLINE PER DAY.
1309	01/01/1900	DRUG HAS BEEN PAID UNDER EQUIVALENT CODE WITHIN SEVEN DAYS OF THIS DOS.
1313	01/01/1900	PHARMACEUTICAL CARE NOT COVERED.
1315	01/01/1900	PATIENT REASON FOR VISIT IS INVALID.
1316	01/01/1900	EXTERNAL CAUSE OF INJURY IS INVALID.
1317	01/01/1900	A REVENUE CODE IS REQUIRED.
1318	01/01/1900	FIFTH OTHER SURGICAL CODE IS INVALID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1319	01/01/1900	FIRST OTHER SURGICAL CODE IS INVALID.
1320	01/01/1900	FOURTH OTHER SURGICAL CODE IS INVALID.
1321	01/01/1900	INCORRECT OR INVALID NDC/PROCEDURE CODE/REVENUE CODE BILLED FOR DATE OF SERVICE.
1322	01/01/1900	INCORRECT OR INVALID NDC/PROCEDURE CODE/REVENUE CODE BILLED.
1323	01/01/1900	ONE OR MORE OTHER PROCEDURE CODES IN POSITION SIX THROUGH 24 ARE INVALID.
1324	01/01/1900	ONE OR MORE ICD PROCEDURE CODES HAS A GENDER RESTRICTION.
1325	01/01/1900	OTHER PROCEDURE CODE IS INVALID.
1326	01/01/1900	PRINCIPAL PROCEDURE CODE IS INVALID.
1327	01/01/1900	PRINCIPAL SURGICAL CODE IS INVALID.
1328	01/01/1900	PROCEDURE CODE IS INVALID.
1329	01/01/1900	THE REVENUE CODE IS INVALID.
1330	01/01/1900	SECOND OTHER SURGICAL CODE IS INVALID.
1331	01/01/1900	REVENUE CODE IS INVALID.
1332	01/01/1900	THE REVENUE CODE IS NOT REIMBURSABLE FOR THE DATE OF SERVICE.
1333	01/01/1900	THIRD OTHER SURGICAL CODE IS INVALID.
1334	01/01/1900	HEADER FROM DATE OF SERVICE IS INVALID.
1335	01/01/1900	HEADER TO DATE OF SERVICE IS INVALID.
1336	01/01/1900	HEADER TO DATE OF SERVICE IS REQUIRED.
1337	01/01/1900	BRAND MEDICALLY NECESSARY NDC REQUIRE PA
1339	01/01/1900	THE DIAGNOSIS CODE AND/OR PROCEDURE CODE AND/OR PLACE OF SERVICE IS NOT REIMBURSABLE FOR TEMPORARILY ENROLLED PREGNANT WOMEN.
1340	01/01/1900	REIMBURSEMENT RATE IS NOT ON FILE FOR MEMBER'S LEVEL OF CARE.
1341	01/01/1900	PROVIDER ID MISSING/UNIDENTIFIABLE.
1342	01/01/1900	DOSINGS FOR NARCOTIC TREATMENT SERVICE PROGRAM ARE LIMITED TO SIX PER SUNDAY THRU SATURDAY CALENDAR WEEK.
1343	01/01/1900	THE NARCOTIC TREATMENT SERVICE PROGRAM LIMITATIONS HAVE BEEN EXCEEDED. REFER TOTHE ONINE HANDBOOK.
1344	01/01/1900	PRESCRIBING PROVIDER NUMBER NOT FOUND.
1345	01/01/1900	SUBMITTED REFERRING PROVIDER NPI IN THE HEADER IS INVALID.
1346	01/01/1900	BILLING PROVIDER IS NOT CERTIFIED FOR THE DISPENSE DATE OF SERVICE.
1347	01/01/1900	BILLING PROVIDER NUMBER IS NOT FOUND OR NOT VALID FOR DATES OF SERVICE.
1348	01/01/1900	PROVIDER NOT ALLOWED TO BILL THIS NDC.
1349	01/01/1900	LTC ACCOMODATION CODE QUANTITY BILLED MUST BE EQUAL TO DETAIL DATE RANGE.
1350	01/01/1900	PRESCRIBER ID QUALIFIER MUST BE 01.
1351	01/01/1900	GENDER RESTRICTION FOR NDC.
1353	01/01/1900	NATIONAL DRUG CODE (NDC) IS INVALID.
1354	01/01/1900	NATIONAL DRUG CODE (NDC) IS NOT ON FILE.
1355	01/01/1900	NATIONAL DRUG CODE (NDC) IS REQUIRED.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1356	01/01/1900	NDC INVALID FOR DISPENSE DATE OF SERVICE
1357	01/01/1900	NDC NOT COVERED FOR CLAIM TYPE.
1358	01/01/1900	NDC RESTRICTED BY MEMBER AGE.
1359	01/01/1900	MEMBER IS ENROLLED IN QMB-ONLY BENEFITS. ONLY MEDICARE CROSSOVER CLAIMS ARE REIMBURSABLE.
1360	01/01/1900	NOT USED - RENDERING PROVIDER IS NOT A CERTIFIED PROVIDER FOR DMAP.
1361	01/01/1900	RENDERING PROVIDER IS NOT A CERTIFIED PROVIDER FOR DELAWARE CANCER TREATMENT PROGRAM.
1362	01/01/1900	DAW NOT ALLOWED FOR NDC.
1363	01/01/1900	THE NATIONAL DRUG CODE (NDC) IS NOT ON FILE FOR THE DISPENSE DATE OF SERVICE.
1364	01/01/1900	THE NATIONAL DRUG CODE (NDC) IS NOT PAYABLE FOR THE PROVIDER TYPE AND/OR SPECIALTY.
1365	01/01/1900	NDC NOT COVERED FOR DATE OF SERVICE.
1366	01/01/1900	NDC NOT COVERED BY FAMILY PLANNING ONLY SERVICES.
1367	01/01/1900	NDC HAS DIAGNOSIS RESTRICTIONS.
1369	01/01/1900	PHARMACUETICAL CARE LIMITATION EXCEEDED.
1370	01/01/1900	MEMBER IS ASSIGNED TO A HOSPICE PROVIDER. ALL SERVICES SHOULD BE COORDINATED WITH THE HOSPICE PROVIDER.
1371	01/01/1900	MEMBER IS ASSIGNED TO A LOCK-IN PRIMARY PROVIDER. ALL SERVICES SHOULD BE COORDINATED WITH THE PRIMARY PROVIDER.
1372	01/01/1900	MEMBER IS ASSIGNED TO AN INPATIENT HOSPITAL PROVIDER. ALL SERVICES SHOULD BE COORDINATED WITH THE INPATIENT HOSPITAL PROVIDER.
1374	01/01/1900	A DIAGNOSIS OF GREATER SPECIFICITY MUST BE USED FOR THE DIAGNOSIS CODE IN POSITIONS 10 THROUGH 24.
1375	01/01/1900	SUBMITTED RENDERING PROVIDER NPI IN THE DETAIL IS INVALID.
1376	01/01/1900	SUBMITTED REFERRING PROVIDER NPI IN THE DETAIL IS INVALID.
1377	01/01/1900	THE PROCEDURE CODE HAS DIAGNOSIS RESTRICTIONS.
1378	01/01/1900	THE REVENUE CODE IS NOT PAYABLE FOR THE DATE OF SERVICE.
1379	01/01/1900	THE SERVICES ARE NOT ALLOWED ON THE CLAIM TYPE FOR THE MEMBER'S BENEFIT PLAN.
1380	01/01/1900	THE SURGICAL PROCEDURE CODE IS NOT COVERED FOR THE DATE(S)OF SERVICE.
1381	01/01/1900	THE SURGICAL PROCEDURE CODE IS NOT PAYABLE FOR DELEWARE CANCER TREATMENT PROGRAM FOR THE DATE OF SERVICE.
1382	01/01/1900	ONE OR MORE DIAGNOSIS CODE(S) IS NOT PAYABLE FOR THE DATE OF SERVICE.
1383	01/01/1900	THE FIRST OCCURRENCE SPAN FROM DATE OF SERVICE IS AFTER THE TO DATE OF SERVICE.
1384	01/01/1900	THE SECOND OCCURRENCE SPAN FROM DATE OF SERVICE IS AFTER TO TO DATE OF SERVICE.
1385	01/01/1900	DISPENSE DATE OF SERVICE IS INVALID.
1386	01/01/1900	BILLING PROVIDER REQUIRED TO BE MEDICARE CERTIFIED TO DISPENSE TO DUAL ELIGIBLES
1387	01/01/1900	OTHER COVERAGE INDICATOR IS INVALID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1388	01/01/1900	THE PROCEDURE CODE IS NOT REIMBURSABLE FOR THE RENDERING PROVIDER TYPE AND/OR SPECIALTY.
1389	01/01/1900	THESE SERVICES ARE NOT ALLOWED FOR MEMBERS ENROLLED IN TUBERCULOSIS-RELATED SERVICES ONLY BENEFIT PLAN.
1392	01/01/1900	COMPOUNDS REQUIRE AT LEAST ONE PAYABLE COVERED DRUG.
1393	01/01/1900	DISCHARGE DATE IS BEFORE THE ADMISSION DATE.
1394	01/01/1900	FROM DATE OF SERVICE IS BEFORE ADMISSION DATE.
1395	01/01/1900	ADMISSION DATE IS ON OR AFTER DATE OF RECEIPT OF CLAIM.
1397	01/01/1900	THE FIFTH CONDITION CODE IS INVALID.
1398	01/01/1900	THE FOURTH CONDITION CODE IS INVALID.
1399	01/01/1900	THE PRIMARY CONDITION CODE IS INVALID.
1400	01/01/1900	THE SECOND CONDITION CODE IS INVALID.
1401	01/01/1900	THE SEVENTH CONDITION CODE IS INVALID.
1402	01/01/1900	THE SIXTH CONDITION CODE IS INVALID.
1403	01/01/1900	THE THIRD CONDITION CODE IS INVALID.
1404	01/01/1900	FIFTH OCCURRENCE CODE IS INVALID.
1405	01/01/1900	ONE OR MORE OCCURRENCE CODE(S) IS INVALID IN POSITIONS NINE THROUGH 24.
1406	01/01/1900	SEVENTH OCCURRENCE CODE IS INVALID.
1407	01/01/1900	SIXTH OCCURRENCE CODE IS INVALID.
1408	01/01/1900	THE FOURTH OCCURRENCE CODE IS INVALID.
1409	01/01/1900	EIGHTH OCCURRENCE CODE IS INVALID.
1410	01/01/1900	THE SECOND OCCURRENCE CODE IS INVALID.
1411	01/01/1900	THE THIRD OCCURRENCE CODE IS INVALID.
1412	01/01/1900	A FOURTH OCCURRENCE CODE DATE IS REQUIRED.
1413	01/01/1900	A SECOND OCCURRENCE CODE DATE IS REQUIRED.
1414	01/01/1900	A THIRD OCCURRENCE CODE DATE IS REQUIRED.
1415	01/01/1900	EIGHTH OCCURRENCE CODE DATE IS INVALID.
1416	01/01/1900	EIGHTH OCCURRENCE CODE DATE IS REQUIRED.
1417	01/01/1900	FIFTH OCCURRENCE CODE DATE IS INVALID.
1418	01/01/1900	FIFTH OCCURRENCE CODE DATE IS REQUIRED.
1419	01/01/1900	ONE OR MORE DATE(S) OF SERVICE IS MISSING FOR OCCURRENCE SPAN CODES IN POSITIONS 9 THROUGH 24.
1420	01/01/1900	ONE OR MORE TO DATE(S) OF SERVICE IS INVALID FOR OCCURRENCE SPAN CODES IN POSITIONS THREE THROUGH 24.
1421	01/01/1900	SEVENTH OCCURRENCE CODE DATE IS INVALID.
1422	01/01/1900	SEVENTH OCCURRENCE CODE DATE IS REQUIRED.
1423	01/01/1900	SIXTH OCCURRENCE CODE DATE IS INVALID.
1424	01/01/1900	SIXTH OCCURRENCE CODE DATE IS REQUIRED.
1425	01/01/1900	THE FOURTH OCCURRENCE CODE DATE IS INVALID.
1426	01/01/1900	THE PRIMARY OCCURRENCE CODE DATE IS INVALID.
1427	01/01/1900	THE SECOND OCCURRENCE CODE DATE IS INVALID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1428	01/01/1900	THE THIRD OCCURRENCE CODE DATE IS INVALID.
1429	01/01/1900	FIFTH OTHER SURGICAL CODE DATE IS REQUIRED.
1430	01/01/1900	FIRST OTHER SURGICAL CODE DATE IS INVALID.
1431	01/01/1900	FIRST OTHER SURGICAL CODE DATE IS REQUIRED.
1432	01/01/1900	FOURTH OTHER SURGICAL CODE DATE IS INVALID.
1433	01/01/1900	FOURTH OTHER SURGICAL CODE DATE IS REQUIRED.
1434	01/01/1900	ONE OR MORE SURGICAL CODE DATE(S) IS INVALID IN POSITIONS 6 THROUGH 24.
1435	01/01/1900	ONE OR MORE SURGICAL CODE DATE(S) IS MISSING IN POSITIONS 6 THROUGH 24.
1436	01/01/1900	FIFTH OTHER SURGICAL CODE DATE IS INVALID.
1437	01/01/1900	SECOND OTHER SURGICAL CODE DATE IS INVALID.
1438	01/01/1900	SECOND OTHER SURGICAL CODE DATE IS REQUIRED.
1439	01/01/1900	THIRD OTHER SURGICAL CODE DATE IS INVALID.
1440	01/01/1900	THIRD OTHER SURGICAL CODE DATE IS REQUIRED.
1441	01/01/1900	ONE OR MORE OCCURRENCE SPAN CODE(S) IS INVALID IN POSITIONS THREE THROUGH 24.
1442	01/01/1900	SECOND OCCURRENCE SPAN CODE IS INVALID.
1443	01/01/1900	ONE OR MORE FROM DATE(S) OF SERVICE IS MISSING FOR OCCURRENCE SPAN CODES IN POSITIONS THREE THROUGH 24.
1444	01/01/1900	ONE OR MORE TO DATE(S) OF SERVICE IS MISSING FOR OCCURRENCE SPAN CODES IN POSITIONS THREE THROUGH 24.
1445	01/01/1900	THE FROM DATE OF SERVICE FOR THE FIRST OCCURRENCE SPAN CODE IS INVALID.
1446	01/01/1900	THE FROM DATE OF SERVICE FOR THE FIRST OCCURRENCE SPAN CODE IS REQUIRED.
1447	01/01/1900	THE FROM DATE OF SERVICE FOR THE SECOND OCCURRENCE SPAN CODE IS INVALID.
1448	01/01/1900	THE FROM DATE OF SERVICE FOR THE SECOND OCCURRENCE SPAN CODE IS REQUIRED.
1449	01/01/1900	THE TO DATE OF SERVICE FOR THE FIRST OCCURRENCE SPAN CODE IS INVALID.
1450	01/01/1900	THE TO DATE OF SERVICE FOR THE FIRST OCCURRENCE SPAN CODE IS REQUIRED.
1451	01/01/1900	THE TO DATE OF SERVICE FOR THE SECOND OCCURRENCE SPAN CODE IS INVALID.
1452	01/01/1900	THE TO DATE OF SERVICE FOR THE SECOND OCCURRENCE SPAN CODE IS REQUIRED.
1453	01/01/1900	VALUE CODE AMOUNT IS MISSING.
1455	01/01/1900	SERVICE (PROCEDURE CODE/MODIFIER COMBINATION) IS NOT REIMBURSABLE FOR DATE OF SERVICE.
1456	01/01/1900	DETAIL QUANTITY BILLED MUST BE GREATER THAN ZERO.
1457	01/01/1900	HEADER TO DATE OF SERVICE IS AFTER THE ICN DATE.
1458	01/01/1900	THE DETAIL FROM DATE OF SERVICE IS AFTER THE DETAIL TO DATE OF SERVICE.
1459	01/01/1900	DETAIL FROM DATE OF SERVICE IS INVALID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1460	01/01/1900	DETAIL FROM DATE OF SERVICE IS REQUIRED.
1463	01/01/1900	THE REVENUE CODE IS NOT PAYABLE BY THE BENEFIT PLAN FOR THE DATE OF SERVICE.
1465	01/01/1900	THE PROCEDURE CODE IS NOT PAYABLE BY THE BENEFIT PLAN FOR THE DATE OF SERVICE.
1466	01/01/1900	ONE OR MORE DIAGNOSIS CODE(S) IS NOT PAYABLE BY DELAWARE CANCER TREATMENT PROGRAM FOR THE DATE OF SERVICE.
1468	01/01/1900	COMPOUND INGREDIENT QUANTITY MUST BE GREATER THAN ZERO.
1470	01/01/1900	INVALID/MISSING PAYER OR PLAN ID ON CLAIM - USE MS_TXIX.
1488	01/01/1900	THE ASSISTANT SURGEON'S TAXONOMY CODE IN THE HEADER IS INVALID.
1489	01/01/1900	THE REFERRING PROVIDER'S TAXONOMY SUBMITTED IN THE HEADER IS INVALID.
1490	01/01/1900	THE ASSISTANT SURGEON'S TAXONOMY IN THE DETAIL IS INVALID.
1491	01/01/1900	THE ATTENDING PROVIDER'S TAXONOMY CODE IN THE HEADER IS INVALID.
1492	01/01/1900	THE BILLING PROVIDER'S TAXONOMY CODE IS MISSING.
1493	01/01/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IN THE HEADER IS NOT VALID.
1494	01/01/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IS MISSING IN THE HEADER.
1495	01/01/1900	THE PERFORMING PROVIDER'S TAXONOMY CODE IN THE DETAIL IS INVALID.
1496	01/01/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IS MISSING IN THE DETAIL.
1497	01/01/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IN THE DETAIL IS NOT VALID.
1498	01/01/1900	PROCESSED PER POLICY
1499	01/01/1900	PROCESSED PER POLICY
1500	01/01/1900	IN-HOME MEDICATION MANAGEMENT MUST BE PERFORMED IN CONJUNCTION WITH ONE OF THEFOLLOWING: FOCUSED ADHERENCE INTERVENTION, MEDICATION DEVICE INSTRUCTION INTERVENTION OR COMPREHENSIVE MEDICATION REVIEW AND ASSESSMENT
1501	01/01/1900	FOCUSED ADHERENCE INTERVENTION OR MEDICATION DEVICE INSTRUCTION INTERVENTION ARE NOT ALLOWED ON SAME DATE OF SERVICE AS A COMPREHENSIVE MEDICATION REVIEW ANDASSESSMENT.
1502	01/01/1900	PC NOT COVERED EFFECTIVE 9/01/2012.
1503	01/01/1900	A RENDERING PROVIDER NUMBER IS REQUIRED.
1504	01/01/1900	PERFORMING PROVIDER NUMBER IS NOT FOUND.
1505	01/01/1900	THE BILLING PROVIDER'S TAXONOMY CODE IN THE HEADER IS INVALID.
1506	01/01/1900	A NATIONAL PROVIDER IDENTIFIER (NPI) IS REQUIRED FOR THE PERFORMING PROVIDER LISTED IN THE HEADER.
1507	01/01/1900	A RENDERING PROVIDER IS NOT REQUIRED BUT WAS SUBMITTED ON THE CLAIM.
1508	01/01/1900	THIS CLAIM WAS PROCESSED USING A PROGRAM ASSIGNED PROVIDER ID NUMBER BECAUSE THE SYSTEM WAS UNABLE TO IDENTIFY THE PROVIDER BY THE NATIONAL PROVIDER IDENTIFIER (NPI) SUBMITTED ON THE CLAIM. PLEASE SUBMIT FUTURE CLAIMS WITH THE APPROPRIATE NPI, TAXONOMY AND/OR ZIP +4 CODE.
1509	01/01/1900	BILLING PROVIDER INDICATED IS NOT CERTIFIED AS A BILLING PROVIDER.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1510	01/01/1900	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1511	01/01/1900	THE ICD PROCEDURE CODE IS NOT PAYABLE FOR THE DATE OF SERVICE.
1512	01/01/1900	THE PROCEDURE CODE/MODIFIER COMBINATION IS NOT PAYABLE FOR THE DATE OF SERVICE.
1514	01/01/1900	FOURTH MODIFIER IS INVALID.
1515	01/01/1900	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SURGICAL PROCEDURE CODE.
1516	01/01/1900	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE REVENUE CODE.
1517	01/01/1900	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1518	01/01/1900	DIAGNOSIS CODE IS RESTRICTED BY MEMBER AGE.
1519	01/01/1900	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1520	01/01/1900	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1521	01/01/1900	PROCEDURE CODE IS NOT ALLOWED ON THE CLAIM FORM/TRANSACTION SUBMITTED.
1522	01/01/1900	SURGICAL PROCEDURE CODE IS NOT ALLOWED ON THE CLAIM FORM/TRANSACTION SUBMITTED.
1523	01/01/1900	AVAILABLE FOR USE
1524	01/01/1900	BILLED AMOUNT EXCEEDS PA AMOUNT.
1525	01/01/1900	FAMILY PLANNING RELATED
1526	01/01/1900	SERVICES BILLED EXCEED PA AMOUNT.
1529	01/01/1900	A MORE SPECIFIC DIAGNOSIS CODE(S) IS REQUIRED.
1530	01/01/1900	CLAIM CONTAINS DUPLICATE SEGMENTS FOR PRESENT ON ADMISSION (POA) INDICATOR.
1531	01/01/1900	INDICATOR FOR PRESENT ON ADMISSION (POA) IS NOT A VALID VALUE.
1532	01/01/1900	CLAIM COUNT OF PRESENT ON ADMISSION (POA) INDICATORS DOES NOT MATCH COUNT OF NON-ADMITTING AND NON-EMERGENCY DIAGNOSIS CODES.
1533	01/01/1900	THE CLAIM DID NOT INCLUDE THE PAYER ID. TXIX WAS ASSIGNED AS THE PAYER FOR THISCLAIM.
1534	01/01/1900	ACCOM REV CODE QTY BILLED NOT EQUAL TO DTL DOS
1535	01/01/1900	EFFECTIVE 04/01/09, THE BADGERCARE PLUS CORE PLAN WILL LIMIT COVERAGE FOR HYPOGLYCEMICS-INSULIN TO HUMALOG AND LANTUS.
1536	01/01/1900	EFFECTIVE 04/01/09, THE BADGERCARE PLUS CORE PLAN WILL LIMIT COVERAGE FOR GLUCOCORTICOIDS-INHALED TO FLOVENT.
1537	01/01/1900	EFFECTIVE 04/01/09, THE BADGERCARE PLUS CORE PLAN WILL LIMIT COVERAGE FOR BROCHODILATORS-BETA AGONISTS TO PROVENTIL HFA AND SEREVENT.
1539	01/01/1900	DAW IS NOT ALLOWED FOR GENERIC DRUG.
1540	01/01/1900	CONTINGENCY PLAN FOR CORE AND HIRSP KIDS - SUSPEND ALL NON-PHARMACY CLAIMS.
1541	01/01/1900	THE PROCEDURE CODE HAS FAMILY PLANNING RESTRICTIONS.
1542	01/01/1900	THE REVENUE CODE HAS FAMILY PLANNING RESTRICTIONS.
1543	01/01/1900	NDC HAS FAMILY PLANNING RESTRICTIONS.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1544	01/01/1900	THE SERVICE IS NOT REIMBURSABLE FOR THE MEMBERS BENEFIT PLAN.
1547	01/01/1900	NO RENDERING PROVIDER STATUS FOUND FOR THE FROM AND TO DATE OF SERVICE.
1548	01/01/1900	NOT USED - CLAIM DATE(S) OF SERVICE MODIFIED TO ADHERE TO DMAP POLICY
1549	01/01/1900	SUM OF DETAIL MEDICARE PAID AMOUNTS DOES NOT EQUAL HEADER MEDICARE PAID AMOUNT.
1550	01/01/1900	TRANSPLANT SERVICES NOT PAYABLE WITHOUT A TRANSPLANT AQUISITION REVENUE CODE.
1552	01/01/1900	THIS PROCEDURE IS AGE RESTRICTED. MEMBER'S AGE DOES NOT FALL WITHIN THE APPROVED AGE RANGE.
1554	01/01/1900	THE CLAIM TYPE AND DIAGNOSIS CODE SUBMITTED ARE NOT PAYABLE.
1555	01/01/1900	NDC REQUIRES PA. FOLLOW CORE PLAN POLICY FOR PA SUBMISSION.
1564	01/01/2010	PAYMENT MAY BE REDUCED DUE TO SUBMITTED "PRESENT ON ADMISSION" (POA) INDICATOR.
1565	01/01/1900	DAPO OVERRIDE REQUIRED TO DISPENSE LESS THAN THREE MONTH SUPPLY.
1566	01/01/1900	DENIED/CUTBACK. ONE BMI INCENTIVE PAYMENT IS ALLOWED PER MEMBER, PER RENDERINGPROVIDER, PER CALENDAR YEAR.
1567	01/01/1900	CORE PLAN MEMBERS ARE LIMITED TO 25 NON-EMERGENCY OUTPATIENT HOSPITAL VISITS PER ENROLLMENT YEAR.
1569	01/01/1900	PDN SERVICES BILLED ON THIS CLAIM EXCEED 12 HOURS/DAY PER NURSE
1570	01/01/1900	PDN SERVICES BILLED ON THIS CLAIM EXCEED 60 HOURS/WEEK PER NURSE
1571	01/01/1900	PDN SERVICES BILLED ON THIS CLAIM EXCEED 24 HOURS/DAY PER MEMBER
1572	01/01/1900	DENIED. HOME HEALTH SERVICES FOR CORE PLAN MEMBERS ARE COVERED ONLY FOLLOWING AN INPATIENT HOSPITAL STAY. HOSPITAL DISCHARGE MUST BE WITHIN 30 DAYS OF FROM DATE OF SERVICE.
1573	01/01/1900	THE TOTAL OF AMOUNTS BILLED FOR THE DOS ON THE CLAIM EXCEEDS THE ALLOWED DAILYLIMIT FOR PDN SERVICES.
1574	01/01/1900	DIABETIC SUPPLY PREVIOUSLY PAID UNDER EQUIVALENT CODE FOR SAME DATE OF SERVICE.
1575	01/01/1900	PURCHASE OF BLOOD GLUCOSE MONITOR INCLUDES DIABETIC SUPPLIES FOR FIRST 30 DAYS.
1576	01/01/1900	MAXALT REQUIRES PA IF MAXALT OR SUMATRIPTAN NOT PAID WITHIN 365 DAYS.
1577	01/01/1900	DENIED. PROCEDURE CODE 00942 IS ALLOWED ONLY WHEN PROVIDED ON THE SAME DATE OFSERVICE AS PROCEDURE CODE 57520.
1578	01/01/1900	TRANSPLANTS AND TRANSPLANT-RELATED SERVICES ARE NOT COVERED UNDER THE BASIC PLAN.
1579	01/01/1900	AN XRAY OR DIAGNOSTIC URINALYSIS IS REIMBURSABLE ONLY WHEN PERFORMED ON THE SAME DATE OF SERVICE AND BILLED ON THE SAME CLAIM AS THE INITIAL OFFICE VISIT.
1581	01/01/1900	THE TRAVEL COMPONENT FOR THIS SERVICE MUST BE BILLED ON THE SAME CLAIM AS THE ASSOCIATED SERVICE.
1582	01/01/1900	CANNOT BILL FOR BOTH ASSAY OF LAB AND OTHER HANDLING/CONVEYANCE OF SPECIMEN.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1588	01/01/1900	QUANTITY DISPENSED MUST BE A MULTIPLE OF THE PACKAGE SIZE.
1589	01/01/1900	DO NOT LEAVE BLANK FIELDS BETWEEN THE MULTIPLE OCCURANCE CODES.
1595	01/01/1990	QUANTITY INDICATED FOR THIS SERVICE EXCEEDS THE MAXIMUM QUANTITY LIMIT ESTABLISHED.
1597	01/01/1900	SERVICE DENIED DUE TO THE AMOUNT BILLED FOR THIS SERVICE EXCEEDS REASONABLE CHARGES FOR THE SERVICE RENDERED. RESUBMIT SERVICE IF BILLED AMOUNT WAS IN ERROR.
1598	01/01/1900	THIS SERVICE WAS NOT ALLOWED TO BYPASS BADGERCARE PLUS FEE-FOR-SERVICE PRIOR AUTHORIZATION (PA) REQUIREMENTS FOR THIS FORMER UNITEDHEALTHCARE (UHC) ENROLLEE.UHC DID NOT INFORM BADGERCARE PLUS THAT THIS MEMBER HAD AN APPROVED PA FOR THISSERVICE AS OF OCTOBER 31, 2012.
1600	01/01/1900	DIAGNOSIS IN DIAGNOSIS CODE FIELD(S) 1 THROUGH 9 IS MISSING OR INCORRECT.
1601	01/01/1900	ERRORS IN ONE OF THE FOLLOWING DATA ELEMENTS EXCEED THEIR FIELD SIZE: STATEMENTCOVERED FROM DATE, ADMISSION DATE, DATE OF SERVICE, REVENUE CODE.
1602	01/01/1900	OCCURANCE CODE OR OCCURANCE DATE IS INVALID.
1603	01/01/1900	CONDITION CODE MUST BE BLANK OR ALPHA NUMERIC A0-Z9.
1604	01/01/1900	THE ATTENDING PHYSICIAN NPI/UPIN ID AND NAME ARE EITHER REQUIRED AND ARE MISSING OR A NPI/UPIN BEGINNING WITH NPP HAS BEEN USED.
1605	01/01/1900	THE FIRST POSITION OF THE ATTENDING UPIN MUST BE ALPHABETIC.
1606	01/01/1900	MODIFIER IS INVALID.
1607	01/01/1900	A DATE OF SERVICE IS REQUIRED WITH THE REVENUE CODE AND HCPCS CODE BILLED.
1608	01/01/1900	THE USE OF VALUE CODE IS INCORRECT.
1609	01/01/1900	A HCPCS CODE IS REQUIRED WHEN CONDITION CODE A6 IS INCLUDED ON THE CLAIM.
1610	01/01/1900	INTERMITTENT PERITONEAL DIALYSIS HOURS MUST BE ENTERED FOR THIS REVENUE CODE.
1611	01/01/1900	VALUE CODES 48 - HOMOGLOBIN READING AND 49 - HEMATOCRIT READING, MUST HAVE A ZERO IN THE FAR RIGHT POSITION.
1612	01/01/1900	THE REVENUE CODE AND HCPCS CODE ARE INCORRECT FOR THE TYPE OF BILL.
1613	01/01/1900	THE REVENUE CODE AND HCPCS CODE ARE INCORRECT FOR THE TYPE OF BILL.
1614	01/01/1900	THE DIAGNOSIS CODE ON THE CLAIM REQUIRES CONDITION CODE A6 BE PRESENT ON THE TYPE OF BILL.
1615	01/01/1900	REVENUE CODE IS NOT VALID FOR THE TYPE OF BILL SUBMITTED.
1616	01/01/1900	THE REVENUE CODE ON THE CLAIM REQUIRES CONDITION CODE 70 TO BE PRESENT FOR THISTYPE OF BILL.
1617	01/01/1900	REVENUE CODE SUBMITTED IS NO LONGER VALID.
1618	01/01/1900	THIS IS A SAME-DAY CLAIM FOR BILL TYPES 13X, 14X, 71X, OR 83X AND THERE ARE MULTIPLE UNITS OR COMBINATION OF CHEMISTRY/HEMOTOLOGY TESTS. PLEASE SHOW THE APPROPRIATE MULTICHANEL HCPCS CODE RATHER THAN THE INDIVIDUAL HCPCS CODE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1619	01/01/1900	CONDITION CODES 71, 72, 73, 74, 75, AND 76 CANNOT BE PRESENT ON THE SAME ESRD CLAIM AT THE SAME TIME.
1620	01/01/1900	CONDITION CODE 70-76 IS REQUIRED ON AN ESRD CLAIM WHEN INFLUENZA/PPV/HEP B HCPCS CODES ARE THE ONLY CODES BEING BILLED WITH CONDITION CODE A6.
1621	01/01/1900	IF CONDITION CODES 71 THROUGH 76 EXIST ON THE CLAIM, THEN REVENUE CODES 082X, 083X, 084X, 085X OR 088X MUST ALSO BE PRESENT.
1622	01/01/1900	REVENUE CODES 0822, 0823, 0825, 0832, 0833, 0835, 0842, 0843, 0845, 0852, 0853,OR 0855 EXIST ON THE ESRD CLAIM THAT DOES NOT CONTAIN CONDITION CODE 74.
1623	01/01/1900	REVENUE CODES 082X, 083X, 084X, 085X, 0800 OR 0881 (X FREQUENCY NOT EQUAL TO 5)EXIST ON AN ESRD CLAIM FOR A MEMBER WHO HAS SELECTED METHOD 1 OR NO METHOD ANDTHE CLAIM DOES NOT CONTAIN CONDITION CODES 71, 72, 73 ,74, 75, OR 76.
1624	01/01/1900	THE CONDITION CODE IS NOT ALLOWED FOR THE REVENUE CODE.
1625	01/01/1900	THE VALUE CODE 48 (HEMOGLOBIN READING) OR 49 (HEMATOCRIT) IS REQUIRED FOR THE REVENUE CODE/HCPCS CODE COMBINATION.
1626	01/01/1900	THIS REVENUE CODE REQUIRES VALUE CODE 68 TO BE PRESENT ON THE CLAIM.
1627	01/01/1900	THE SUBMITTED CLAIM CONTAINS VALUE CODE 68 AND 48 OR 49 BUT DOES NOT CONTAIN REVENUE CODE 0634 OR 0635 AND HCPCS Q4055. -OR- THE CLAIM CONTAINS VALUE CODE 49BUT DOES NOT CONTAIN REVENUE CODE 0636 AND HCPCS Q4054. -OR- THE CLAIM CONTAINSVALUE CODE 48, 49, OR 68 BUT DOES NOT CONTAIN REVENUE CODES 0634 OR 0635.
1628	01/01/1900	REVENUE CODE 082X IS PRESENT ON AN ESRD CLAIM WHICH ALSO CONTAINS REVENUE CODE088X (X FREQUENCY NON EQUAL TO 9).
1629	01/01/1900	REVENUE CODE 082X IS PRESENT ON AN ESRD CLAIM WHICH ALSO CONTAINS REVENUE CODES083X, 084X, OR 085X.
1630	01/01/1900	ALL ESRD CLINICAL DIAGNOSTIC LABORATORY TESTS MUST BE BILLED INDIVIDUALLY TO ENSURE THAT AUTOMATED MULTI-CHANEL CHEMISTRY TESTS ARE PAID IN ACCORDANCE WITH THE MEDICARE PROVIDER REIMBURSEMENT MANUAL (PRM) 2711.
1631	01/01/1900	THE APPROPRIATE MODIFER OF CD, CE OR CF ARE REQUIRED ON THE CLAIM TO IDENTIFY WHETHER OR NOT THE AMCC TESTS ARE INCLUDED IN THE COMPOSITE RATE OR NOT INCLUDEDIN THE COMPOSITE RATE.
1632	01/01/1900	A VALUE CODE OF A8 OR A9 IS REQUIRED.
1633	01/01/1900	MEDICALLY UNBELIEVABLE ERROR. THE MAXIMUM LIMITATION FOR DOSAGES OF EPO IS 500,000 UI'S (VALUE CODE 68) PER MONTH AND THE MAXIMUM LIMITATION FOR DOSAGES OF ARANESP IS 1500 MCG (1 UNIT=1 MCG) PER MONTH. PLEASE CORRECT AND RESUBMIT.
1634	01/01/1900	EXCESSIVE HEIGHT AND/OR WEIGHT REPORTED ON CLAIM. ESRD CLAIMS ARE NOT ALLOWED WHEN SUBMITTED WITH VALUE CODE OF A8 (WEIGHT) AND A WEIGHT OF MORE THAN 500 KILOGRAMS AND/OR THE VALUE CODE OF A9 (HEIGHT) AND THE HEIGHT OF MORE THAN 900 CENTIMETERS.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1635	01/01/1900	VALUE CODE 48 EXCEEDS 13.0 OR VALUE CODE 49 EXCEEDS 39.0 AND HCPCS CODES Q4081OR J0882 ARE PRESENT BUT EITHER MODIFER ED OR EE ARE NOT PRESENT.
1636	01/01/1900	A 72X TYPE OF BILL IS SUBMITTED WITH REVENUE CODE 0821, 0831 0841, 0851, 0880,OR 0881 AND COVERED CHARGES OR UNITS GREATER THAN 1.
1637	01/01/1900	THE STATEMENT COVERAGE FROM DATE ON A HEMODIALYSIS ESRD CLAIM (REVENUE CODE 0821, 0880, OR 0881) WAS GREATER THAN THE HEMODIALYSIS TERMINATION DATE IN THE PROVIDER FILE.
1638	01/01/1900	THE NUMBER OF TREATMENTS/DAYS REFLECTED BY THE UNITS ENTERED WITH REVENUE CODE0821, 0831, 0841, 0851, 0880, 0881 EXCEEDS THE NUMBER OF DAYS INCLUDED IN THE FROM AND TO DATES ENTERED ON THIS CLAIM.
1639	01/01/1900	X-RAYS AND SOME LAB TESTS ARE NOT BILLABLE ON A 72X CLAIM.
1640	01/01/1900	PAYMENT HAS BEEN REDUCED OR DENIED BECAUSE THE MAXIMUM ALLOWANCE OF THIS ESRD SERVICE HAS BEEN REACHED.
1641	01/01/1900	THE NUMBER OF UNITS BILLED FOR DIALYSIS SERVICES EXCEEDS THE ROUTINE LIMITS.
1642	01/01/1900	THE CLAIM CONTAINS A REVENUE CODE AND/OR HCPCS THAT PRICE BY A FEE AMOUNT, BUTTHE RATE FIELD IS BLANK OR CONTAINS ZEROS ON THE HCPCS FILE.
1643	01/01/1900	THIS IS A DUPLICATE CLAIM. PLEASE ADJUST QUANTITIES ON THE PREVIOUSLY SUBMITTEDAND PAID CLAIM.
1644	01/01/1900	VALID OTHER PAYER DATE REQUIRED.
1645	01/01/1900	OTHER PAYER DATE AFTER CLAIM RECEIPT DATE.
1646	01/01/1900	VALID OTHER PAYER REJECT CODE REQUIRED.
1647	01/01/1900	OTHER PAYER DATE IS INVALID
1648	01/01/1900	REPACKAGED NDCS NOT COVERED.
1649	01/01/1900	REVENUE CODE REQUIRES SUBMISSION OF ASSOCIATED HCPCS CODE
1651	01/01/1900	LENGTH OF OBSERVATION EXCEEDS MAXIMUM LIMIT.
1654	01/01/1900	PROCEDURE NOT PAYABLE FOR THIS BENEFIT PLAN.
1655	01/01/1900	A SPLIT CLAIM IS REQUIRED WHEN THE SERVICE DATES ON YOUR CLAIM OVERLAPS YOUR FEDERAL FISCAL YEAR END (FYE) DATE.
1656	01/01/1900	CONDITION CODE 80 IS PRESENT WITHOUT CONDITION CODE 74. PLEASE VERIFY BILLING.REFERENCE: TRANSMITTAL 477, CHANGE REQUEST 3720 ISSUED FEBRUARY 18, 2005.
1657	01/01/1900	REVENUE CODE BILLED WITH MODIFIER GL MUST CONTAIN NON-COVERED CHARGES.
1658	01/01/1900	HCPCS PROCEDURE CODES G0008, G0009 OR G0010 ARE ALLOWED ONLY WITH REVENUE CODE0771.
1659	01/01/1900	MORE THAN ONE PPV OR INFLUENZA VACCINE BILLED ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER IS NOT ALLOWED.

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1660	01/01/1900	CLAIM CONTAINS AN UNCLASSIFIED DRUG HCPCS PROCEDURE CODE OR A DRUG HCPCS PROCEDURE CODE INCLUDED IN THE COMPOSITE RATE. ADDITIONAL INFORMATION IS NEEDED FOR UNCLASSIFIED DRUG HCPCS PROCEDURE CODES. SEPARATE REIMBURSEMENT FOR DRUGS INCLUDED IN THE COMPOSITE RATE IS NOT ALLOWED.
1661	01/01/1900	THE HCPCS PROCEDURE CODE LISTED FOR REVENUE CODE 0624 IS EITHER INVALID OR NON-REIMBURSEABLE.
1662	01/01/1900	DATE OF SERVICE IS ON OR AFTER JULY 1, 2010 AND TOB IS 72X, VALUE CODE D5 MUSTBE PRESENT.
1663	01/01/1900	FOR DATES OF SERVICE ON OR AFTER 7/1/10 FOR TOB 72X AN OCCURRENCE CODE 51 AND VALUE CODE D5 ARE REQUIRED WHEN THE KT/V READING WAS PERFORMED. IF THE KT/V READING WAS NOT PERFORMED, THEN THE VALUE CODE D5 WITH 9.99 MUST BE PRESENT WITHOUT THE OCCURRENCE CODE 51.
1664	01/01/1900	MODIFIER V8 OR V9 MUST BE SUMBITTED WITH REVENUE CODE 0821, 0831, 0841, OR 0851.
1665	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. MEMBER ID NOT PRESENT.
1666	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. FINANCIAL PAYER NOT INDICATED.
1667	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. PROVIDER ID NOT PRESENT.
1668	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT RQST. CLAIM ICN/RX NOT FOUND.
1669	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. ORIGINAL ICN NOT PRESENT.
1670	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. MEMBER NOT FOUND.
1671	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. PROVIDER NOT FOUND.
1672	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. ORIGINAL CLAIM ICN NOT FOUND.
1673	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. CLAIM HAS ALREADY BEEN ADJUSTED.
1674	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. A DIFFERENT ADJUSTMENT IS PENDING FOR THIS CLAIM.
1675	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. THIS CLAIM IS IN POST PAY BILLING FOR THIRD PARTY LIABILITY PAYMENT.
1676	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. CLAIM CAN NO LONGER BE ADJUSTED. CONTACT PROVIDER SERVICES FOR FURTHER INFORMATION.
1677	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. THE CLAIM TYPE OF THE ADJUSTMENT DOES NOT MATCH THE CLAIM TYPE OF THE ORIGINAL CLAIM.
1678	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. MEMBER ID NUMBER ON THE CLAIM AND ON THE ADJUSTMENT REQUEST DO NOT MATCH.
1679	01/01/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. PROVIDER ID/OR BILLING ADDRESS ON THE CLAIM AND ON THE ADJUSTMENT REQUEST DO NOT MATCH.
1680	01/01/1900	MODIFIER V5, V6, OR V7 MUST BE INCLUDED ON THE LATEST LINE ITEM DATE OF SERVICEBILLING REVENUE CODE 0821.
1681	01/01/1900	CONDITION CODE 73 FOR SELF CARE CANNOT EXCEED A QUANTITY OF 15.
1682	01/01/1900	THE INITIAL RENTAL OF A NEGATIVE PRESSURE WOUND THERAPY PUMP IS LIMITED TO 90 DAYS; MEMBER LIFETIME.

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EOB Code	Effective Date	Description
1683	01/01/1900	ADDITIONAL RENTAL OF A NEGATIVE PRESSURE WOUND THERAPY PUMP IS LIMITED TO 90 DAYS IN A 12 MONTH PERIOD.
1684	01/01/1900	THE CANISTER, DRESSINGS AND RELATED SUPPLIES ARE INCLUDED AS PART OF THE REIMBURSEMENT FOR THE NEGATIVE PRESSURE WOUND THERAPY PUMP.
1685	01/01/1900	BILLING PROVIDER TYPE AND SPECIALTY IS NOT ALLOWABLE FOR THE PLACE OF SERVICE.
1686	01/01/1900	THIS SERVICE IS NOT PAYABLE WITH ANOTHER SERVICE ON THE SAME DATE OF SERVICE DUE TO NATIONAL CORRECT CODING INITIATIVE.
1689	01/01/1900	NOT USED - DMAP DOES NOT REIMBURSE BOTH THE GLOBAL SERVICE AND THE INDIVIDUAL COM PONENT PARTS OF THE SERVICE FOR THE SAME DATE OF SERVICE.
1690	01/01/1900	QUANTITY INDICATED FOR THIS SERVICE EXCEEDS THE MAXIMUM QUANTITY LIMIT ESTABLISHED BY THE NATIONAL CORRECT CODING INITIATIVE.
1691	01/01/1900	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	01/01/1900	ADJUSTMENT AND ORIGINAL CLAIM DO NOT HAVE THE SAME FINANICAL PAYER
1696	01/01/1900	THERE ARE NO SEPARATELY REIMBURSABLE DIALYSIS SERVICES ON THIS ESRD CLAIM
1697	01/01/1900	PRICING ADJUSTMENT - REDUCTION OF REIMBURSEMENT WHEN SERVICE IS RENDERED IN A HOSPITAL OR AMBULATORY SURGERY CENTER.
1702	01/01/1900	NOT USED - DMAP REIMBURSES THESE SERVICES BY A BUNDLED RATE (PER DIEM, DRG). THER EFORE, THESE SERVICES DENIED BY MEDICARE ARE NOT SEPARATELY REIMBURSABLE BY FORWARDHEALTH.
1703	01/01/1900	CONSULTANT REVIEW HAS NOT OCCURRED DUE TO INSUFFICIENT JUSTIFICATION PROVIDED ON PHARMACY SPECIAL HANDLING REQUEST.
1704	01/01/1900	BOOSTER COVID VACCINE ADMINISTRATION
1705	01/01/1900	MENTAL HEALTH INJECTABLE DRUGS ONLY COVERED THROUGH POS FOR MEMBERS RESIDING INLONG TERM CARE FACILITIES. ALL OTHER PTs BILL ON MEDICAL CLAIMS.
1706	01/01/1900	ANXIOLYTIC INJECTIONS ARE ONLY COVERED THROUGH POS FOR MEMBERS RESIDING IN LTCFACILITIES. ALL OTHER PATIENTS REQUIRE PA.
1710	01/01/1900	MEMBER ENROLLED IN MEDICAID
1712	01/01/1900	CLAIM DENIED FOR WRONG SURGICAL OR OTHER INVASIVE PROCEDURE PERFORMED ON A PATIENT.
1713	01/01/1900	CLAIM DENIED FOR WRONG SURGICAL OR OTHER INVASIVE PROCEDURE PERFORMED ON A PATIENT.
1715	01/01/1900	TOOTH NUMBER IS AGE RESTRICTED. MEMBER'S AGE DOES NOT FALL WITHIN THE APPROVEDAGE RANGE.
1716	01/01/1900	DISCHARGE HOUR IS INVALID FORMAT.
1717	01/01/1900	DETAIL DATES OF SERVICE MUST SPAN 1 MONTH FOR PROCEDURE CODE BILLED.
1718	01/01/1900	DETAIL DATES OF SERVICE MUST SPAN 1 MONTH FOR REVENUE CODE BILLED.
1719	01/01/1900	BILLED AMOUNT CAN NOT EXCEED 1 MILLION DOLLARS.
1720	01/01/1900	MEDICARE PAID AMOUNT GREATER THAN OR EQUAL TO MEDICARE ALLOWED AMOUNT.

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EOB Code	Effective Date	Description
1721	01/01/1900	TOTAL DAYS STAY DOES NOT EQUAL THE COVERED DAYS. PLEASE VERIFY YOUR BILLING, CORRECT AND RESUBMIT.
1722	01/01/1900	YOU ARE BILLING AN INPATIENT CLAIM WITH A PATIENT STATUS OF 30 (STILL A PATIENT). BILLINGS ARE NOT ACCEPTED UNTIL THE PATIENT IS DISCHARGED. SEE BILLING INSTRUCTIONS.
1723	01/01/1900	PROCEDURE REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASERESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
1724	01/01/1900	CLAIM REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASE RESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
1725	01/01/1900	CLAIM BILLED FOR REHAB SERVICES UNDER YOUR ACUTE CARE PROVIDER NUMBER/TAXONOMY.PHYSICAL REHAB SERVICES MUST BE BILLED UNDER YOUR PHYSICAL REHAB PROVIDER NUMBER/TAXONOMY.
1726	01/01/1900	CLAIM BILLED FOR AN ACCOMMODATION REVENUE CODE IN A SUBCATEGORY OTHER THAN REHAB. PHYSICAL REHAB PROVIDER NUMBER/TAXONOMY CANNOT BE CONSIDERED AS PRESENT.
1727	01/01/1900	MODIFIER HO OR HP INCONSISTENT WITH PROVIDER TAXONOMY.
1728	01/01/1900	POS CLAIM WAS SUBMITTED BEYOND THE 100 DAY TIMELY FILING LIMIT.
1729	01/01/1900	DIAGNOSIS REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASERESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
1730	01/01/1900	SEALANT AND SURFACE COMBINATION INVALID.
1731	01/01/1900	RESPITE CARE NOT COVERED IN NURSING HOME FACILITY.
1732	01/01/1900	DRUG NAME REQUIRED.
1733	01/01/1900	CLAIM REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASE RESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
1734	01/01/1900	TOOTH NUMBER AND PROCEDURE REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH ISMISSING. PLEASE RESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
1735	01/01/1900	PLEASE RESUBMIT AS A POS CLAIM.
1736	01/01/1900	MULTIPLE PERFORMING PROVIDERS. MUST HAVE THE SAME PERFORMING PROVIDER FOR ALL DETAILS.
1737	01/01/1900	PRESCRIBER NAME MISMATCH OR INVALID.
1738	01/01/1900	PROVIDER NOT ELIGIBLE TO PROVIDE SERVICES TO QMB MEMBER.
1739	01/01/1900	MEMBER DATE OF DEATH INVALID.
1740	01/01/1900	MEMBER DATE OF BIRTH INVALID.
1741	01/01/1900	SERVICE COVERED BY PACE.
1742	01/01/1900	TPL AMOUNT APPLIED AND PATIENT RESPONSIBILITY IS ZERO.NO PAYMENT ALLOWED.
1743	01/01/1900	TPL ONLY REQUIRED AT THE HEADER.
1744	01/01/1900	TPL ONLY REQUIRED AT THE DETAIL.
1745	01/01/1900	TPL NOT BALANCED FOR CLAIM.
1746	01/01/1900	MEMBER DATE OF DEATH DOES NOT MATCH FILE.
1747	01/01/1900	DATE OF SERVICE IS AFTER MEMBER DATE OF DEATH ON FILE.
1748	01/01/1900	MEMBER BIRTH DATE DOES NOT MATCH FILE.
1749	01/01/1900	MEMBER GENDER DOES NOT MATCH FILE.

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1750	01/01/1900	MEMBER NOT ELIGIBLIE FOR VFC PROCEDURE.
1752	01/01/1900	QUANITY UNITS BILLED OUTSIDE THE LIMITS.
1753	01/01/1900	PROCEDURE REQUIRES BILLING OF 5 DAYS OF SERVICES.
1754	01/01/1900	PROCEDURE REQUIRES BILLING OF 30 DAYS OF SERVICES.
1755	01/01/1900	PROVIDER NOT CERTIFIED FOR ANESTEHESIA PROCEDURE.
1756	01/01/1900	REVENUE CODE NOT BILLABLE FOR RENDERING PROVIDER SERVICE LOCATION.
1757	01/01/1900	REVENUE CODE NOT BILLABLE FOR BILLING PROVIDER SERVICE LOCATION.
1758	01/01/1900	REVENUE CODE NOT BILLABLE FOR MEMBER SERVICE LOCATION.
1759	01/01/1900	LOCKIN PLANS CAN NOT OVERLAP DATE OF SERVICE.
1760	01/01/1900	DATES OF SERVICES SPAN ICD-9 AND ICD-10 TIME FRAMES.
1761	01/01/1900	INVALID PROCEDURE CODE MODIFIER COMBINATION FOR CLIA ON FILE.
1762	01/01/1900	TOOTH NUMBER INVALID FOR TOOTH SURFACE F AND I.
1763	01/01/1900	TOOTH NUMBER INVALID FOR TOOTH SURFACE B AND O.
1764	01/01/1900	MEMBER HAS ILLEGAL ALIEN PLAN WITH DCTP COVERAGE.
1765	01/01/1900	CLAIM SUSPENDED FOR MANUAL REVIEW
1766	01/01/1900	ICD CODE IS AGE RESTRICTED. MEMBER'S AGE DOES NOT FALL WITHIN THE APPROVED AGERANGE.
1767	01/01/1900	REVENUE CODE IS AGE RESTRICTED. MEMBER'S AGE DOES NOT FALL WITHIN THE APPROVEDAGE RANGE.
1768	01/01/1900	TPL PAY AND CHASE SERVICES
1769	01/01/1900	INPATIENT CLAIM PROCESSED USING DISCHARGE RATE.
1770	01/01/1900	PAID ACCORDING TO MEDICAID ALLOWED AMOUNT
1798	01/01/1900	PROVIDER HAS MEDICARE ONLY INFORMATIONAL CONTRACT
1801	01/01/1900	REFILL INDICATOR INVALID.
1807	01/01/1900	UNABLE TO PROCESS. CALL PROVIDER SERVICES.
1808	01/01/1900	BILLING PROVIDER ID NOT ON FILE.
1809	01/01/1900	RENDERING PROVIDER IS NOT CERTIFIED.
1810	01/01/1900	NPI IS REQUIRED FOR BILLING PROVIDER.
1815	01/01/1900	QMB-ONLY MEMBER RESTRICTED TO MEDICARE CROSSOVER CLAIMS.
1816	01/01/1900	NDC NOT REIMBURSABLE FOR DATE OF SERVICE
1818	01/01/1900	HEADER FACILITY PROVIDER NUMBER IS NOT FOUND.
1819	01/01/1900	VERIFY BILLED AMOUNT AND QUANTITY BILLED. IF CORRECT, RESUBMIT THE CLAIM.
1821	01/01/1900	PRESCRIBER IS NOT A MEDICAID PROVIDER. PRESCRIBER HAS 90 DAYS FROM THE DATE OFFIRST CLAIM SUBMITTED TO MEDICAID TO ENROLL AS PROVIDER UNTIL CLAIMS DENY.
1822	01/01/1900	NOT USED - NATIONAL CORRECT CODING INITIATIVES. DMAP HAS APPROVED THE PROCEDUREF OR THIS DATE OF SERVICE.
1824	01/01/1900	MCO ID IS INVALID OR NOT PRESENT ON ENCOUNTER CLAIM.
1825	01/01/1900	PROVIDER ATTESTATION NOT FOUND FOR 340B CLAIMS
1830	01/01/1900	RENDERING PROVIDER NOT ELIGIBLE/REVALIDATED - RECYCLE 21 DAYS
1831	01/01/1900	RENDERING PROVIDER NOT ELIGIBLE/REVALIDATED - DENY

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1832	01/01/1900	BILLING PROVIDER NOT ELIGIBLE/REVALIDATED - RECYCLE 21 DAYS
1833	01/01/1900	BILLING PROVIDER NOT ELIGIBLE/REVALIDATED - DENY
1897	01/01/1900	THE FACILITY PROVIDER'S TAXONOMY CODE AT THE DETAIL IS INVALID, MISSING, OR DOES NOT MATCH THE TAXONOMY ON FILE.
1903	01/01/1900	THE FACILITY PROVIDER'S TAXONOMY CODE IN THE HEADER IS INVALID, MISSING, OR DOES NOT MATCH THE TAXONOMY ON FILE
1920	01/01/1900	THE REFERRING PROVIDER'S TAXONOMY SUBMITTED AT THE DETAIL IS INVALID
1922	01/01/1900	THE REFERRING PROVIDER'S TAXONOMY SUBMITTED AT THE DETAIL IS MISSING
1929	01/01/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR REFERRING PROVIDER LISTEDIN THE HEADER.
1930	01/01/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE FACILITY PROVIDER LISTED IN THE HEADER.
1932	01/01/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE OTHER PROVIDER LISTEDIN THE HEADER.
1933	01/01/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE OTHER PROVIDER LISTEDAT THE DETAIL.
1934	01/01/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE RENDERING PROVIDER LISTED AT THE DETAIL.
1935	01/01/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR REFERRING PROVIDER LISTEDIN THE DETAIL.
1937	01/01/1900	NOT USED - DMAP IS UNABLE TO IS PROCESS THIS CLAIM AT THIS TIME.AN ALERT WILLBE POSTED TO THE FORWARDHEALTH PORTAL ON HOW TO RESUBMIT.
1941	01/01/1900	INVALID INTERNAL OTHER PROV SPECIFIED - HDR
1942	01/01/1900	INVALID INTERNAL OTHER PROV SPECIFIED - DTL
2001	01/01/1900	MEMBER ID IS INCORRECT. BILL USING THE FIRST 9 NUMERIC VALUES ON THE ID CARD AND NO LEADING ZEROS.
2012	01/01/1900	INDIVIDUAL BILLING PROVIDER MUST ALSO BE THE RENDERING PROVIDER
2013	01/01/1900	GROUP BILLING PROVIDER NOT ALLOWED FOR CLAIM TYPE
2020	01/01/1900	PROVIDER LICENSE EXPIRED
2022	01/01/1900	DATE OF SERVICE BEFORE MEMBER'S DATE OF BIRTH
2025	01/01/1900	MEMBER NOT COVERED FOR OUTPATIENT PHARM BENEFITS FOR DOS (HPE SERVICE MODIFIER)
2030	01/01/1900	BENEFICIARY (K-BABY'S MOTHER) IS NOT FEMALE OR IS NOT AT LEAST 8 YRS OLD ON DOSOR IS NOT ELIGIBLE FOR MEDICAID ON DOS
2031	01/01/1900	BABY'S GENDER CODE IS MISSING OR INVALID.
2032	01/01/1900	BABY OVER AGE ONE-REBILL UNDER BABY'S MEDICAID ID
2034	01/01/1900	PHARMACY CLAIMS NOT COVERED FOR INM MEMBERS
2037	01/01/1900	MEMBER ID HAS CHANGED. NO ACTION REQUIRED.
2040	01/01/1900	NDC IS OBSOLETE FOR THE DATE OF SERVICE.
2054	01/01/1900	UNABLE TO DETERMINE MEMBER AID CATEGORY
2060	01/01/1900	MEMBER IS NOT ELIGIBLE FOR WAIVER SERVICES
2222	01/01/1900	POLICY NOT CURRENTLY ENFORCED.

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2257	01/01/1900	PRIMARY DIAGNOSIS CODE IS NOT PRESENT ON THE CLAIM. A PRIMARY DIAGNOSIS CODE WILL SOON BE REQUIRED WHEN SUBMITTING DENTAL CLAIMS TO THE MS DIVISION OF MEDICAID. VISIT MEDICAID.MS.GOV LATE BREAKING NEWS PAGE FOR MORE DETAILS.
2268	01/01/1900	MEMBER ENROLLED IN MEDICARE PART D. CLAIM IS EXCLUDED FROM DRUG REBATE INVOICING.
2277	01/01/1900	ADMIT HOUR INVALID
2302	01/01/1900	FLUORIDE AND PROPHYLAXIS BUNDLED LIMITED TO ONE PER PROVIDER PER DAY
2304	01/01/1900	MULTIPLE RADIATION THERAPY MANAGEMENT SESSIONS BILLED SAME DAY
2305	01/01/1900	NARRATIVE AND TOOTH NUMBER OR LETTER REQUIRED FOR PALLIATIVE TREATMENT.
2306	01/01/1900	OCCUPATIONAL THERPAY EVALUATION BILLED SAME DAY AS OCCUPATIONAL THERAPY SESSION
2307	01/01/1900	PAYMENT HAS BEEN MADE TO ANOTHER PROVIDER FOR THIS SERVICE FOR THE SAME DATE.VERIFY YOUR BILLING, CORRECT AND RESUBMIT, OR RESUBMIT WITH DOCUMENTATION.
2310	01/01/1900	PHYSICAL THERPAY EVALUATION BILLED SAME DAY AS PHYSICAL THERAPY SESSION
2311	01/01/1900	PORTIONS OF THIS CLAIM APPEAR TO BE A DUPLICATE OF ANOTHER CLAIM WHICH HAS ALREADY BEEN PAID. IF YOU HAVE QUESTIONS PLEASE CALL HPES PROVIDER SERVICES
2313	01/01/1900	PROCEDURE REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASERESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
2316	01/01/1900	SERVICE LIMITED TO EVERY SIX MONTHS
2317	01/01/1900	SERVICE LIMITED TO EVERY THREE YEARS
2318	01/01/1900	SERVICE LIMITED TO FIFTEEN PER YEAR
2319	01/01/1900	SERVICE LIMITED TO FIVE PER LIFETIME
2320	01/01/1900	SERVICE LIMITED TO FOUR LIFETIME
2324	01/01/1900	SERVICE LIMITED TO ONE PER 210 DAYS
2325	01/01/1900	SERVICE LIMITED TO ONE PER 280 DAYS
2326	01/01/1900	SERVICE LIMITED TO ONE PER DAY
2327	01/01/1900	SERVICE LIMITED TO ONE PER LIFETIME
2330	01/01/1900	SERVICE LIMITED TO ONE PER YEAR
2331	01/01/1900	SERVICE LIMITED TO TWO DOSES OF VARICELLA AGES 1 THROUGH 19
2332	01/01/1900	SERVICE LIMITED TO TWO PER LIFETIME
2333	01/01/1900	SERVICE ROUTINELY COVERED ONCE PER 36 MONTHS. PAYMENT HAS ALREADY BEEN MADE TOYOU OR ANOTHER PROVIDER. THIS CLAIM WILL NOT BE PAID.
2334	01/01/1900	SERVICE ROUTINELY COVERED ONCE PER SIX MONTHS. PAYMENT HAS ALREADY BEEN MADE TOYOU OR ANOTHER PROVIDER.
2335	01/01/1900	SERVICES LIMITED TO ONE EVERY 45 DAYS.
2336	01/01/1900	SPECIFIED SERVICES BILLED SAME DAY SAME PROVIDER
2337	01/01/1900	SPEECH THERAPY EVALUATION BILLED SAME DAY AS SPEECH THERAPY SESSION
2338	01/01/1900	SURGERY PROCEDURE BILLED SAME DAY AS HOSPITAL VISIT SAME PROVIDER

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2339	01/01/1900	SURGERY PROCEDURE BILLED WITHIN 45 DAY PERIOD PRIOR TO OFFICE OR HOME VISIT SAME PROVIDER
2340	01/01/1900	SURGERY PROCEDURE BILLED WITHIN THREE DAYS OF HOSPITAL ADMISSION BY SAME PROVIDER
2342	01/01/1900	THE HCPCS PROCEDURE CODE BILLED IS INCLUDED IN THE REIMBURSEMENT FOR THE PRIMARY SERVICE/PROCEDURE
2344	01/01/1900	THIS CROSSOVER CLAIM IS A DUPLICATE OF A MEDICAID-ONLY CLAIM WHICH HAS ALREADYBEEN PAID. VOID THE ORIGINAL CLAIM AND RESUBMIT THE CROSSOVER FOR PAYMENT. CALLHPES IF ANY QUESTIONS.
2345	01/01/1900	YOU ARE BILLING A HOSPITAL READMISSION FOR THE SAME ADMITTING DIAGNOSIS WITHIN10 DAYS OF INITIAL DISCHARGE. THIS CLAIM WILL NOT BE PAID.
2346	01/01/1900	YOU ARE BILLING FOR A COMPREHENSIVE LEVEL OF SERVICE. REVIEW DEFINITION IN CPTBOOK. CORRECT LEVEL (IF IN ERROR) OR RESUBMIT WITH DOCUMENTATION TO JUSTIFY SERVICE.
2352	01/01/1900	YOU HAVE BILLED FOR A HOSPITAL ADMISSION FOR ANOTHER DATE OF SERVICE WITHIN THREE DAYS. REVIEW. IF CORRECT, RESUBMIT WITH DOCUMENTATION FOR BOTH DATES OF SERVICE.
2353	01/01/1900	YOU ARE BILLING THE SAME PROCEDURE CODE ON MULTIPLE CLAIM LINES. REVIEW AND RESUBMIT ONE CLAIM LINE. COMBINE THE UNITS AND CHARGES AS APPROPRIATE.
2354	01/01/1900	BILLING PROVIDER NUMBER IS FOR AN INDIVIDUAL, THEREFORE, THE DETAIL PERFORMINGPROVIDER NUMBER MUST BE THE SAME AS THE BILLING PROVIDER NUMBER.
2355	01/01/1900	THIS CLAIM IS DENIED AS AN EXACT DUPLICATE OF EITHER: 1. ANOTHER CLAIM LINE ONTHE SAME CLAIM FORM, 2. ANOTHER DENIED CLAIM LINE ON THIS RA OR, 3. ANOTHER PREVIOUSLY PD CLAIM LINE
2356	01/01/1900	IF RUNNING MULTIPLE TESTS ON SAME SPECIMEN, BILL THE CODE THAT ACCURATELY DESCRIBES THE COMPLETE TEST. IF SEPARATE SPECIMENS, RESUBMIT WITH BOTH TEST RESULTS
2358	01/01/1900	DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE PROCEDURE CODE BILLED. PLEASE REVIEW, CORRECT, OR SUBMIT FURTHER DOCUMENTATION
2359	01/01/1900	THIS PROCEDURE IS NOT REIMBURSABLE WHEN PERFORMED AT THE SAME TIME OR IN IMMEDIATE SEQUENCE WITH ANOTHER SURGICAL PROCEDURE
2360	01/01/1900	PROCEDURES DESIGNATED IN CPT AS SEPARATE PROCEDURES ARE INCLUDED IN THE REIMBURSEMENT FOR THE PRIMARY PROCEDURE
2361	01/01/1900	AN ANESTHESIA RECORD FOR THIS SURGICAL PROCEDURE IS NEEDED IN ORDER TO DETERMINE PROPER RESOLUTION OF THIS CLAIM.PLEASE RESUBMIT WITH THIS DOCUMENTATION
2362	01/01/1900	REVIEW THE PRACTITIONER MANUAL - USE THE SPECIFIC HCPCS PROCEDURE CODE FOR THESERVICE RENDERED
2363	01/01/1900	DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE DATE OF SERVICE BILLED. PLEASE REVIEW, CORRECT, OR SUBMIT FURTHER DOCUMENTATION.
2368	01/01/1900	THE OPERATIVE NOTE SHOULD CLEARLY DOCUMENT WHAT THE ASSISTANT SURGEON DID DURING THE OPERATIVE SESSION.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
2377	01/01/1900	COMPLETE UPPER DENTURES ALLOWED ONCE EVERY FIVE YEARS
2378	01/01/1900	COMPLETE LOWER DENTURES ALLOWED ONCE EVERY 5 YEARS
2379	01/01/1900	PARTIAL UPPER DENTURES ALLOWED ONCE EVERY 5 YEARS
2380	01/01/1900	PARTIAL LOWER DENTURES ALLOWED ONCE EVERY 5 YEARS
2381	01/01/1900	ADJUSTMENTS ALLOWED ONLY ONCE EVERY 6 MONTHS
2382	01/01/1900	1 DENTURE RELINE EVERY 2 YEARS
2386	01/01/1900	YOU HAVE BILLED A RESTORATION FOR THE SAME TOOTH AND THE SAME SURFACE FOR ANOTHER DATE OF SERVICE. REVIEW. IF CORRECT, RESUBMIT WITH DOCUMENTATION FOR BOTH DATES OF SERVICE.
2387	01/01/1900	YOU HAVE PREVIOUSLY BILLED RESTORATION FOR SAME TOOTH/SURFACE.DOCO SUBMITTED DOESN?T SUBSTANTIATE NEED FOR 2ND RESTORATION.RESUBMIT WITH ADD'L INFO TO DOCUMENT NEED FOR TREATMENT.
2388	01/01/1900	YOU HAVE BILLED FOR PROPHYLAXIS FOR ANOTHER DATE OF SERVICE WITHIN 6 MONTHS. IFADDITIONAL PROPHYLAXIS MEDICALLY NECESSARY, SUBMIT REQUEST FOR PRIOR AUTHORIZATION.
2389	01/01/1900	THIS CLAIM IS DENIED AS A DUPLICATE BECAUSE YOU ARE BILLING MORE THAN ONE PROPHYLAXIS ON THE SAME DAY.
2390	01/01/1900	ANOTHER PROVIDER HAS ALREADY BEEN PAID FOR THE EXTRACTION OF THIS TOOTH
2391	01/01/1900	PAYMENT HAS ALREADY BEEN MADE TO YOU OR ANOTHER PROVIDER FOR THE EXTRACTION OFTHIS TOOTH. REVIEW. IF CORRECT, RESUBMIT WITH DOCUMENTATION.
2399	01/01/1900	INVALID - MEDICARE DEDUCTIBLE PRESENT ON INTERIM BILL
2401	01/01/1900	PAYMENT HAS ALREADY BEEN MADE TO ANOTHER PROVIDER FOR A HOSPITAL ADMISSION WITHIN THREE DAYS. REVIEW YOUR RECORDS. CORRECT OR RESUBMIT WITH SUPPORTIVE DOCUMENTATION.
2402	01/01/1900	PAYMENT HAS ALREADY BEEN MADE TO ANOTHER PROVIDER FOR A HOSPITAL ADMISSION ON THIS DATE OF SERVICE. REVIEW YOUR RECORDS. CORRECT OR RESUBMIT WITH SUPPORTIVE DOCUMENTATION.
2403	01/01/1900	DOCUMENTATION DOES NOT JUSTIFY SERVICES BILLED
2404	01/01/1900	YOU HAVE BILLED MORE THAN ONE VISIT PER DAY FOR A CODE THAT IS DEFINED AS A PERDAY SERVICE. REVIEW YOUR BILLING AND ADJUST/RESUBMIT IF NECESSARY.
2444	01/01/1900	DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE THE NUMBER OF UNITS BILLED. PLEASE REVIEW, CORRECT NUMBER OF UNITS BILLED OR SUBMIT FURTHER DOCUMENTATION.
2445	01/01/1900	DME PROVIDERS ARE ALLOWED TO DISPENSE NO MORE THAN A 1 MONTH SUPPLY AT A TIME.RESUBMIT WITH DOCUMENTATION THAT THE QUANTITY BILLED CONSTITUTES A 1 MONTH SUPPLY.
2448	01/01/1900	THIS CLIENT IS ELIGIBLE FOR INPATIENT SERVICES ONLY. THIS CLAIM WILL NOT BE PAID BY DELAWARE MEDICAID. SUBMIT TO YOUR DEPARTMENT OF CORRECTIONS MEDICAL SERVICES CONTRACTOR.
2449	01/01/1900	YOU ARE BILLING A PROCEDURE CODE THAT REQUIRES MANUAL PRICING. RESUBMIT WITH ACOPY OF YOUR INVOICE THAT DESCRIBES THE ITEM AND GIVES AN ITEMIZED EXPLANATIONOF ALL CHARGES

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2450	01/01/1900	BILLING A PROCEDURE CODE THAT REQUIRES AN ATTACHMENT FOR MANUAL PRICING.
2453	01/01/1900	PLEASE RESUBMIT WITH CONSENT OR AWARENESS FORM PER SECTION 2.5 OF THE PRACTITIONER PROVIDER POLICY MANUAL
2454	01/01/1900	THE FORM ATTACHED IS NOT LEGIBLE
2455	01/01/1900	THE ATTACHED FORM MUST BE COMPLETED IN ITS ENTIRETY
2456	01/01/1900	FEDERAL STERILIZATION CONSENT FORM IS REQUIRED
2458	01/01/1900	BENEFITS FOR NON-CITIZENS ARE LIMITED TO EMERGENCY/LABOR/DELIVERY. THE SERVICEYOU ARE BILLING DOES NOT MEET THE CRITERIA FOR COVERAGE AND WILL NOT BE PAID.
2459	01/01/1900	THIS MEMBER IS ENROLLED IN A MANAGED CARE ORGANIZATION.THE SERVICE BILLED IS ONLY COVERED IF PROVIDED BY THAT PLAN.
2460	01/01/1900	CLIENT 21 OR OVER ON DATE OF SERVICE. NOT ELIGIBLE FOR EPSDT SERVICES
2462	01/01/1900	PROCEDURE WITHOUT A MODIFIER INCONSISTENT WITH THE PLACE OF SERVICE.
2465	01/01/1900	REVENUE CODE BILLED NOT ALLOWED FOR PROVIDER WITHOUT JUSTIFICATION.
2467	01/01/1900	EOB PAID AMOUNT DOES NOT MATCH AMOUNT IN AMOUNT PAID BOX ON CLAIM FORM
2468	01/01/1900	PART A EXHAUSTED CLAIMS FOR INPATIENT SERVICES MUST BE SUBMITTED ON PAPER WITHAN EOMB THAT CLEARLY STATES THE BENEFIT IS EXHAUSTED.
2469	01/01/1900	CLIENT HAS MEDICARE. BILL MEDICARE FIRST OR TRANSMIT A VALID DENIAL REASON CODE.
2470	01/01/1900	CLIENT ON EOB DOES NOT MATCH CLIENT ON THE CLAIM FORM
2471	01/01/1900	CLIENT HAS MEDICARE. BILL MEDICARE FIRST OR ATTACH MEDICARE DENIAL.
2472	01/01/1900	INVALID TPL VOUCHER ATTACHED. TPL VOUCHER IS EITHER FOR ANOTHER INDIVIDUAL, DIFFERENT DATES OF SERVICE, OR DIFFERENT INSURANCE CARRIER. PLEASE CORRECT AND RESUBMIT.
2473	01/01/1900	INSURANCE PAYMENT/DENIAL INFORMATION IS INCOMPLETE
2474	01/01/1900	DENIAL REASON ON EXPLANATION OF BENEFITS IS NOT SUFFICIENT OR IS UNACCEPTABLE.
2475	01/01/1900	MEDICAID WILL NOT COVER SERVICES DENIED BY THE PRIMARY INSURANCE BECAUSE THE RULES OF THE PRIMARY INSURANCE WERE NOT FOLLOWED.
2476	01/01/1900	MEMBBER HAS OTHER INSURANCE. ATTACH OTHER INSURANCE PAYMENT OR DENIAL.
2477	01/01/1900	ATTACH A COPY OF THE INSURANCE EOB WITH THE DENIAL REASON.
2478	01/01/1900	DENIAL REASON ON EXPLANATION OF BENEFITS IS NOT SUFFICIENT OR IS UNACCEPTABLE.
2479	01/01/1900	CLIENT ON EOB DOES NOT MATCH CLIENT ON THE CLAIM FORM
2480	01/01/1900	EOMB INFORMATION IS UNDER REVIEW
2481	01/01/1900	MEMBER HAS MORE THAN ONE INSURANCE CARRIER. RESUBMIT WITH ALL EOB'S
2482	01/01/1900	PART OF THIS CLM IS COVRD BY OTHER INS. RESUBMIT WITH EOB FOR COVERED CHARGES

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2483	01/01/1900	INVALID TPL VOUCHER. TPL VOUCHER STATES THAT THIS CLAIM IS A DUPLICATE OF ANOTHER CLAIM PREVIOUSLY PROCESSED. PLEASE ATTACH CORRECT VOUCHER SHOWING PAYMENT ORDENIAL AND RESUBMIT.
2484	01/01/1900	THE MEDICARE EOMB WAS ATTACHED TO THE CLAIM BUT THE PATIENT'S MEDICARE SUPPLEMENT PLAN VOUCHER WAS MISSING. PLEASE ATTACH AND RESUBMIT.
2485	01/01/1900	INVALID TPL VOUCHER ATTACHED. TPL VOUCHER IS EITHER FOR ANOTHER INDIVIDUAL, DIFFERENT DATES OF SERVICE, OR DIFFERENT INSURANCE CARRIER. PLEASE CORRECT AND RESUBMIT.
2486	01/01/1900	A SEPARATE CLAIM MUST BE SUBMITTED FOR EACH CLAIM NUMBER ON THE INSURANCE EOB.
2487	01/01/1900	THIS CLAIM IS DENIED BECAUSE THE DATE OF SUBMISSION IS OVER SIX MONTHS FROM THEDATE OF THE TPL VOUCHER.
2490	01/01/1900	AN OPERATIVE REPORT IS REQUIRED IN ORDER TO DETERMINE PROPER REIMBURSEMENT.
2491	01/01/1900	TPL VOUCHER PAID DATE IS MISSING. PLEASE RECOPY VOUCHER SO THE PAID DATE APPEARS AND RESUBMIT.
2493	01/01/1900	MEMBER IS ELIGIBLE FOR SERVICES ONLY WHEN ACTIVELY ENROLLED IN A DSHP OR A DHCPMCO. YOU ARE BILLING FOR DATE OF SERVICE OUTSIDE ACTIVE ENROLLMENT. THIS CLAIMWILL NOT BE PAID.
2494	01/01/1900	THE PRESCRIPTION ORIGIN CODE IS INVALID. THIS CLAIM WILL NOT BE PAID
2495	01/01/1900	NET CLAIMS NOT COVERED FOR CERTAIN AID CATEGORIES
2496	01/01/1900	Header paid amount exceeds billed amount
2497	01/01/1900	DAILY DOSAGE IS EXCESSIVE. VERIFY UNITS AND DAY SUPPLY FIELDS ARE CORRECTLY POPULATED. CONTACT THE HPE PROVIDER HELP DESK FOR ADDITIONAL ASSISTANCE
2498	01/01/1900	MENTAL HEALTH SERVICES FOR CHILDREN UNDER AGE 18 MUST BE APPROVED BY AND BILLEDTO THE DIVISION OF CHILD MENTAL HEALTH. CONTACT CMH AT 1-800-722-7710 FOR MOREINFORMATION.
2499	01/01/1900	ADJUDICATION DATE OLDER THAN 365 DAYS.
2500	01/01/1900	MULTIPLE CLAIMS FOUND.
2501	01/01/1900	REVERSAL NOT ALLOWED FOR CLAIM STATUS.
2502	01/01/1900	REVERSAL NOT PROCESSED.
2503	01/01/1900	YOU ARE BILLING A "SICK" OFFICE VISIT CODE WITH A "WELL" DIAGNOSIS. REVIEW. CORRECT. SEE PRACTITIONER MANUAL, PROVIDER SPECIFIC POLICY, PREVENTIVE MEDICINESECTION.
2504	01/01/1900	PATIENT MUST BE AT LEAST 21 YEARS OF AGE WHEN SIGNING THE CONSENT FORM.
2505	01/01/1900	STERILIZATION DID NOT MEET THE 30 DAY WAITING PERIOD.
2506	01/01/1900	DATE OF STERILIZATION MUST NOT BE MORE THAN 180 DAYS AFTER THE PATIENT SIGNED THE CONSENT FORM.
2507	01/01/1900	PREMATURE DELIVERY WITH STERILIZATION REQUIRES EXPECTED DATE OF DELIVERY.

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EOB Code	Effective Date	Description
2508	01/01/1900	PERSON OBTAINING CONSENT MUST SIGN AND DATE THE CONSENT FORM THE SAME DAY AS THE PATIENT.
2509	01/01/1900	DATES OF THE SURGERY ON THE CONSENT FORM AND CLAIM DO NOT MATCH.
2510	01/01/1900	PHYSICIAN MUST SIGN AND DATE THE CONSENT FORM ON OR AFTER THE DATE OF SERVICE.
2511	01/01/1900	BONY IMPACTED WISDOM TEETH PROCEDURES MUST BE SUBMITTED ON A PROFESSIONAL CLAIMFORM.
2512	01/01/1900	YOU ARE BILLING A SURGICAL PROCEDURE. YOU HAVE ALSO BILLED AN OFFICE VISIT WITHIN 45 DAYS OF THIS PROCEDURE. RESUBMIT THE SURGICAL PROCEDURE WITH OFFICE VISIT NOTES.
2513	01/01/1900	MEDICARE PART C CLAIM FILED FOR MEMBER. MEMBER DOES NOT HAVE MEDICARE PART C ADVANTAGE PLAN ON FILE.
2514	01/01/1900	THIS CLAIM APPEARS TO BE A DUPLICATE OF ANOTHER CLAIM. PLEASE RESUBMIT WITH DISCHARGE AND ADMIT HOURS COMPLETED.
2515	12/08/2017	INTERIM BILLING: SUBMIT THE TOTAL CHARGES FROM THE ORIGINAL FROM DATE OF SERVICE (ADMIT DATE) ON ALL SUBSEQUENT INTERIM CLAIMS.
2516	01/31/2018	INTERIM BILLING: PLEASE CONTACT GAINWELL TECHNOLOGIES PROVIDER RELATIONS FOR INSTRUCTIONS REGARDING SUBMISSION OF INTERIM CLAIMS.
2517	01/01/2016	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM ALREADY PAID TO YOU OR ANOTHER PROVIDER FOR PART C COGNITIVE SKILLS DEVLOPMENT SERVICES.
2518	01/01/2014	PLEASE ATTACH THE REQUIRED NOTICE OF DENIAL FROM THE MCO TO INDICATE SERVICES HAVE BEEN EXHAUSTED. ONE PER CALENDAR YEAR IS REQUIRED.
2519	01/01/2014	THE DOCUMENTATION YOU HAVE ATTACHED DOES NOT MATCH THE CLAIM.
2520	01/01/2014	SERVICES ARE OUTSIDE THE PARAMETERS OF THE PERIODICITY SCHEDULE.
2521	01/01/2014	CLIENT IS ONLY ELIGIBLE FOR PAYMENT OF MEDICARE PREMIUMS AND IS NOT ELIGIBLE FOR MEDICAID SERVICES. THIS CLAIM WILL NOT BE PAID.
2603	01/01/1900	MUST BILL HOSPICE. IF HOSPICE PAYS THE CLAIM, IT WILL BE CONSIDERED PAID IN FULL. IF HOSPICE REJECTS DUE TO NONCOVERAGE SUBMIT A '03' IN OTHER COVERAGE CODE FIELD 308-C8
2605	01/01/1900	MEMBER IS ASSIGNED TO A LOCKIN PLAN. SERVICES MUST BE RENDERED BY THE LOCKIN PROVIDER.
2613	01/01/1900	MSCAN ENCOUNTER SUBMITTED WITH $0 CCO PD AMT AND CARC WAS MISSING OR INVALID
2614	01/01/1900	CCO DENIED ENCOUNTERS BASED ON THE CAS REASON CODES
2617	01/01/1900	MSCHIP ENCOUNTER SUBMITTED WITH $0 CCO PD AMT AND CARC WAS MISSING OR INVALID
2618	01/01/1900	CCO RENDERING PROVIDER NOT FOUND ON AFFILIATION FILE
2620	01/01/1900	CCO CHP BLN PROVIDER NOT FOUND ON AFFILIATION FILE
2622	01/01/1900	OUT OF NETWORK BILLING PROVIDER NOT CHIP PROVIDER
2631	01/01/1900	M/I COMPOUND INGREDIENT DRUG COST
2633	01/01/1900	MISSING OR INVALID PRODUCT/SERVICE ID QUALIFIER
2638	01/01/1900	THIRD-PARTY COVERAGE AND NO AMOUNT WAS RECOVERED
2668	01/01/1900	72 HOUR EMERGENCY FILL

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EOB Code	Effective Date	Description
2669	01/01/1900	DRUG NOT ALLOWED FOR 72 HOUR FILL
2678	01/01/1900	CCO DID NOT SUBMIT ENCOUNTER CLAIM WITHIN 30 DAYS OF ORIGINAL RECEIPT FROM PHARMACY
2679	01/01/1900	ENCOUNTER ADJUSTMENT CLAIM TOO OLD
2693	01/01/1900	MEMBER IS ELIGIBLE FOR LONG TERM CARE AND THE DATE OF SERVICE FALLS WITHIN A STOP PAYMENT SEGMENT.
2698	01/01/1900	340B CLAIM SUBMISSION CLARIFICATION/COST BASIS CODE COMBO INVALID OR MISSING
2706	01/01/1900	MEMBER'S AGE IS LESS THAN RECOMMENDED AGE FOR DRUG. PA REQUIRED.
2707	01/01/1900	CALCULATED DAILY DOSE LESS THAN MINIMUM DAILY DOSE.
2708	01/01/1900	NO DOSE INFORMATION FOR AGE.
2709	01/01/1900	NO DOSE INFORMATION FOR AGE; DIFFERENT AGE WILL BE USED TO CALCULATE DOSING.
2715	01/01/1900	MAX ADULT DAILY DOSE EXCEEDED
2716	01/01/1900	MAX PEDIATRIC DAILY DOSE EXCEEDED
2717	01/01/1900	MAX GERIATRIC DAILY DOSE EXCEEDED
2815	01/01/1900	NEW ADMIN PROVIDER HOLD
2819	01/01/1900	REFERRING PROVIDER NPI MISSING FOR ADMIT SOURCE
3001	01/01/1900	MEMBER IS NOT COVERED FOR THE NDC BILLED FOR THE DATE OF SERVICE.
3003	01/01/1900	DUR+ CALLED
3019	01/01/1900	SERVICES FOR THIS DATE OF SERVICE HAVE BEEN PREVIOUSLY PAID. PROVIDERS MAY ADJUST A PREVIOUSLY PAID CLAIM FOR THIS DATE OF SERVICE TO REQUEST REIMBURSEMENT FOR ADDITIONAL SERVICES PROVIDED DURING THE SAME OUTPATIENT HOSPITAL VISIT.
3020	01/01/1900	BILLING TAXONOMY IS NOT ALLOWABLE FOR THE REVENUE CODE BILLED.
3021	01/01/1900	MEDICARE PAYMENT AMOUNTS MUST BE INDICATED FOR EACH DETAIL OF THE CLAIM. MEDICARE PAID, ALLOWED, COPAYMENT, COINSURANCE, DEDUCTIBE AND/OR BLOOD DEDUCTIBLE MUST NOT BE REPORTED AT THE HEADER LEVEL OF CLAIMS.
3022	01/01/1900	FOWARDHEALTH REQUIRES BOTH THE MEDICARE ALLOWED AMOUNT AND MEDICARE PAID AMOUNTAND ONE OR MORE OF THE FOLLOWING AMOUNTS: DEDUCTIBLE, COINSURANCE AND/OR COPAYMENT, ON ALL CROSSOVER CLAIMS. CLAIMS WILL BE DENIED IF THE MEDICARE PAYMENTS ARE NOT INDICATED ON THE CLAIM AT THE DETAIL LEVEL.
3024	01/01/1900	SERVICE MET REQUIREMENTS FOR THE ACA PRIMARY CARE RATE INCREASE.
3025	01/01/1900	SERVICE MET REQUIREMENTS FOR THE ACA PRIMARY CARE RATE INCREASE. HOWEVER, THISSERVICE QUALIFIES FOR AN ENHANCED MEDICAID REIMBURSEMENT RATE, WHICH IS HIGHERTHAN THE ACA PRIMARY CARE RATE INCREASE, SO THE ENHANCED MEDICAID RATE WAS APPLIED.
3026	01/01/1900	DENIED. BILATERAL PROCEDURES MUST BE BILLED WITH MODIFIER RT AND/OR LT ON THE DETAIL(S). RT AND LT CANNOT BE BILLED ON THE SAME DETAIL. DETAILS BILLED WITH NOMODIFIERS OR MODIFIERS NOT ALLOWED FOR THE PROCEDURE CODE WILL BE DENIED. REFER TO THE FORWARDHEALTH UPDATE 2012-43 AND THE DME INDEX FOR ADDITIONAL INSTRUCTIONS AND RULES.

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3027	01/01/1900	DENIED. TWO OR MORE NDCS CANNOT BE BILLED ON A SINGLE DETAIL ON A PROFESSIONALCLAIM WHEN A HCPCS CODE IS BILLED.
3028	01/01/1900	DETAIL CARRIER MUST ALSO BE PRESENT IN THE HEADER.
3029	01/01/1900	CLAIM FILING VALUE IS INVALID.
3030	01/01/2014	COVERAGE LIMITED TO FEDERAL LEGEND DRUGS OR OVER-THE-COUNTER DRUGS.
3032	01/01/1900	NEWLY RELEASED DRUG, MANUAL PRIOR AUTHORIZATION IS REQUIRED
3034	01/01/1900	THE SUM OF COVERED PLUS NON-COVERED DAYS IS NOT EQUAL TO THE DATE RANGE INDICATED ON THE CLAIM.
3036	01/01/1900	A VALID ENROLLED PRESCRIBING/REFERRING/ORDERING PROVIDER IS REQUIRED AND MAY ONLY PRESCRIBE, REFER OR ORDER SERVICES WITHIN THEIR LEGAL SCOPE OF PRACTICE.
3041	01/01/1900	SUBMITTING MCO IS NOT THE ENROLLED MCO OF THE MEMBER.
3042	01/01/1995	OTHER PAYER IDENTIFIER HAS BEEN DUPLICATED
3044	01/01/1900	DENIED. MEMBER IS NO LONGER ENROLLED IN CARE4KIDS.
3045	01/01/1900	DENIED. MEMBER IS NOW ENROLLED IN CARE4KIDS.
3046	01/01/1900	DENIED. SERVICE IS NOT COVERED BY THE MEMBER'S PROGRAM.
3048	01/01/1900	MANIFESTATION DIAGNOSES CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS
3049	01/01/1900	EXTERNAL CAUSE OF MORBIDITY (ECM) DIAGNOSIS CODE(S) ARE INVALID AS THE PRINCIPAL DIAGNOSIS
3050	01/01/1900	A MORE SPECIFIC DIAGNOSIS CODE IS REQUIRED FOR THIS DETAIL
3051	01/01/1900	NONSPECIFIC DIAGNOSIS CODES CANNOT BE USED
3052	01/01/1900	NONSPECIFIC ICD PROCEDURE CODES CANNOT BE USED
3053	01/01/1900	THIS DETAIL CONTAINS DATES THAT OVERLAP WITH ANOTHER DETAIL ON THE SAME CLAIM OR OF ANOTHER PAID DETAIL ON A PREVIOUS CLAIM.
3056	01/01/1900	AMBULANCE MILEAGE REQUIRES A PAID EQUIVALENT AMBULANCE BASE CODE; BASIC LIFE SUPPORT (BLS), ADVANCED LIFE SUPPORT (ALS) OR NON-EMERGENCY MEDICAL TRANSPORT (NEMT).
3100	01/01/1900	PA REQUIRED -PA MISSING OR INVALID
3101	01/01/1900	PA NUMBER NOT ON FILE
3102	01/01/1900	PA REQUIRED - AWAITING PRIOR AUTH
3103	01/01/1900	PA REQUIRED AND NOT FOUND
3104	01/01/1900	PA/MEMBER CONFLICT
3105	01/01/1900	PA/PROVIDER CONFLICT
3106	01/01/1900	PA/PROCEDURE CONFLICT
3107	01/01/1900	PA/MODIFIER CONFLICT
3108	01/01/1900	PA/TOOTH NUMBER CONFLICT
3109	01/01/1900	PA/TOOTH SURFACE CONFLICT
3110	01/01/1900	PA/REVENUE CODE CONFLICT
3111	01/01/1900	PA/DATE OF SERVICE CONFLICT
3112	01/01/1900	PA LINE ITEM IS NOT APPROVED OR HAS BEEN EXHAUSTED
3113	01/01/1900	PA IS NOT APPROVED
3114	01/01/1900	PRICING PA REQUIRED

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3115	01/01/1900	INSUFFICIENT AVAILABLE PA UNITS
3116	01/01/1900	INSUFFICIENT AVAILABLE PA DOLLARS
3117	01/01/1900	INPATIENT PA NOT FOUND
3118	01/01/1900	PA PAYMENT CODE CONFLICT
3160	01/01/1900	COMPOUND CLAIMS ONLY ALLOWED WITH A PRIOR AUTHORIZATION
3161	01/01/1900	MUST HAVE TRIAL OF ANY TWO PREFERRED BPH AGENTS AND DIAGNOSIS OF BPH AND ABSENCE OF ED. PRESCRIBER MUST SUBMIT STATEMENT THAT HE/SHE IS NOT TREATING PATIENT FOR ED.
3162	01/01/1900	DRUG / PA REQUIRES CLINICAL REVIEW.
3163	01/01/1900	CLAIM IS FOR A NON-PREFERRED EPINEPHRINE AUTO-INJECTION. USE GENERIC LABELER 49502 FOR PREFERRED EPINEPHRINE AUTO INJECTION.
3164	01/01/1900	MEMBERS AGE IS LESS THAN RECOMMENDED MIN AGE FOR THIS DRUG. MUST SUBMIT AGE WAIVER SIGNED BY PRESCRIBER FOR APPROVAL.
3165	01/01/1900	CIPRO HC REQ PA FOR MEMBERS AGE 9 YRS AND UP. REFER TO PDL FOR PREFERRED MEDS FOR TX OF ACUTE OTITIS EXTERNA.
3166	01/01/1900	CHANTIX 1 MG CONT MONTH PAK REQ PA IF MEMBERS AGE IS LESS THAN RECOMMENDED MINAGE 18 YRS.
3167	01/01/1900	CIPRODEX REQ PA FOR MEMBERS AGE 15 YRS AND UP. REFER TO PDL FOR PREFERRED MEDSFOR TX OF ACUTE OTITIS EXTERNA.
3168	01/01/1900	ROSACEA AGENTS REQ MANUAL PA WITH DIAGNOSIS FOR MEMBERS AGE 21 YRS AND UP. ACNEVULGARIS AND SEBORRHEIC DERMATITIS AGENTS ARE LIMITED TO AGE < 21 YRS.
3169	01/01/1900	FERTILITY TREATMENT IS NOT COVERED BY MEDICAID, HOWEVER OTHER INDICATIONS WILLBE CONSIDERED FOR COVERAGE. PRESCRIBER MAY SUBMIT A PRIOR AUTHORIZATION REQUEST.
3170	01/01/1900	AMPYRA REQUIRES CLINICAL REVIEW.
3171	01/01/1900	REQUESTED COLONY STIMULATING FACTOR IS NON-PREFERRED AND REQUIRES A MANUAL PA FOR APPROVAL. PLEASE REFER TO THE PDL FOR A LIST OF PREFERRED AGENTS.
3172	01/01/1900	BROVANA AND PERFOROMIST ARE INDICATED FOR AGE >/= 18 YEARS. MUST SUBMIT AGE WAIVER SIGNED BY PRESCRIBER FOR APPROVAL.
3173	01/01/1900	NONPREFERRED REQUIRES PA. PLEASE REFER TO THE PDL FOR A LIST OF PREFERRED AGENTS. IF NON COVERED NUTRITIONAL AND IF AGE < 21 PRESCRIBER MAY SUBMIT MEDICAL NECESSITY PA FORM FOR EPSDT ELIGIBLE MEMBER.
3174	01/01/1900	INGREZZA REQUIRES A MANUAL PA FOR APPROVAL.
3175	01/01/1900	KESIMPTA, MAVENCLAD, MAYZENT, PONVORY AND TASCENSO ODT REQUIRE A CLINICAL REVIEW FOR APPROVAL.
3176	01/01/1900	REBATED KIT LIST REQUIRES PA. NON REBATED NOT COVD.
3177	01/01/1900	REQUESTED RX IS FOR NONPREFERRED ATRIPLA. PLEASE DISPENSE GENERIC EFAVIRENZ/EMTRICITABINE/TENOFOVIR.

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3178	01/01/1900	REQUESTED RX IS FOR NONPREFERRED ATRIPLA OR GENERIC EFAVIRENZ/EMTRICITABINE/TENOFOVIR. PLEASE DISPENSE PREFERRED AUTHORIZED GENERIC EFAVIRENZ/EMTRICITABINE/TENOFOVIR LABELER CODE 00093.
3179	01/01/1900	BILL VIA MEDICAL CLAIM, PA REQUIRED FOR POS VENUE.
3180	01/01/1900	DAKLINZA, EPCLUSA, HARVONI, MAVYRET, SOVALDI, VOSEVI, AND ZEPATIER REQUIRE A CLINICAL REVIEW.
3181	01/01/1900	FASENRA SYRINGES, NUCALA VIALS, AND CINQAIR ARE NOT SELF-ADMINISTERED AND CANNOT BE BILLED THROUGH POS. PLEASE BILL THROUGH MEDICAL VENUE.
3182	01/01/1900	ORTIKOS ER REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3183	01/01/1900	CARISOPRODOL WITH CODEINE REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3184	01/01/1900	LINDANE SHAMPOO REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3185	01/01/1900	KALYDECO, ORKAMBI, SYMDEKO, AND TRIKAFTA REQUIRE A CLINICAL REVIEW FOR APPROVAL.
3186	01/01/1900	ZEPOSIA REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3187	01/01/1900	RESTASIS MULTIDOSE VIALS ARE NON-PREFERRED. PLEASE DISPENSE PREFERRED RESTASISDROPERETTES.
3188	01/01/1900	PROAIR DIGIHALER REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3189	01/01/1900	ZONTIVITY REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3190	12/27/2022	CINQAIR IS NOT SELF-ADMINISTERED AND CANNOT BE BILLED THROUGH POS. PLEASE BILLTHROUGH MEDICAL VENUE.
3204	01/01/1900	SERVICE IS NOT COVERED FOR THE DIAGNOSIS INDICATED.
3206	01/01/1900	DENIED. DIAGNOSIS CODE IS NOT ALLOWABLE.
3208	01/01/1900	DENIED. PROCEDURE BILLED NOT A COVERED SERVICE FOR DATES INDICATED.
3212	01/01/1900	PRESCRIBER ID AND QUALIFIER DO NOT MATCH
3268	01/01/1900	MEMBER ENROLLED IN MEDICARE PART D. CLAIM IS EXCLUDED FROM DRUG REBATE INVOICING.
3301	01/01/1900	A PROCEDURE FOR WHICH THERE IS NO BILATERAL CODE BUT WHICH IS PERFORMED BILATERALLY IN ONE OPERATIVE SESSION IS REPORTED AS TWO UNITS OF SERVICE WITH THE SAMEPROCEDURE CODE.
3302	01/01/1900	DELAWARE MEDICAID DOES NOT COVER ANY SERVICES RELATING SOLELY TO THE TREATMENTOF INFERTILITY.
3303	01/01/1900	YOU ARE BILLING PREVENTIVE MEDICINE SERVICE WITH GYNECOLOGICAL EXAM DIAGNOSIS.RESUBMIT WITH NOTES TO DOCUMENT FULL PREVENTIVE MEDICINE SERVICE OR REBILL USING ANNUAL GYN EXAM CODE.
3304	01/01/1900	YOU ARE BILLING A "SICK VISIT CODE" WITH GYNECOLOGICAL EXAM DIAGNOSIS. RESUBMITWITH SUPPORTING DOCUMENTATION OR REBILL USING ANNUAL GYN EXAM CODE.
3305	01/01/1900	RECIPIENT IS ELIGIBLE FOR EMERG SVCS/LABOR/DELIVERY ONLY. STERILIZATION IS NOT A COVERED SVC. REBILL FOR CHARGES ASSOCIATED WITH THE DELIVERY ONLY.
3306	01/01/1900	DENIED. MEDICARE ALLOWED AMOUNT REQUIRED.
3308	01/01/1900	DENIED. FROM DATE OF SERVICE/DATE FILLED IS MISSING/INVALID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
3314	01/01/1900	DENIED. DETAIL DATES ARE NOT WITHIN STATEMENT COVERED PERIOD.
3315	01/01/1900	A NURSING HOME ACCOMMODATION CLAIM HAS ALREADY BEEN PAID FOR THE CALENDAR MONTHBILLED. PLEASE ADJUST AS NECESSARY.
3316	01/01/1900	ANOTHER PROVIDER HAS BEEN PAID FOR THE SAME OR OVERLAPPING DOS. PRIOR AUTHORIZATION IS REQUIRED WHEN MORE THAN ONE AGENCY IS PROVIDING SERVICES TO THE SAME CLIENT ON THE SAME DATE.
3317	01/01/1900	CHIROPRACTIC MANIPULATIONS LIMITED TO 20 PER YEAR.
3318	01/01/1900	NOT USED - DMAP COVERS A MAXIMUM OF 3 DOSES.
3319	01/01/1900	DSCYF BUNDLED RATE AND RTC STAY MAY NOT BE BILLED FOR THE FULL MONTH.
3321	01/01/1900	CUMULATIVE EARLY REFILL LIMITED TO 4 EVERY 120 DAYS.
3323	01/01/1900	MEDICAID COVERS NINE PREVENTIVE MEDICINE SERVICES FOR THE HEALTHY INDIVIDUAL UNDER AGE ONE. PAYMENT HAS ALREADY BEEN MADE FOR NINE VISITS.
3333	01/01/1900	CCO ENCOUNTER CLAIM IS DENIED.
3335	01/01/1900	ADMIT DIAGNOSIS IS INVALID FOR THE DATE(S) OF SERVICE
3342	01/01/1900	Inpatient Per Diem Rate Not Found
3351	01/01/1900	SERVICE NOT COVERED FOR LTC MEMBER
3358	01/01/1900	ALLOWED AMOUNT EXCEEDS THRESHOLD
3368	01/01/1900	DRG CODE MISSING/INVALID ON ENCOUNTER CLAIM
3375	01/01/1900	FPW SERVICES ARE NON-COVERED WHEN CLAIM CONTAINS NON-FPW DIAGNOSIS CODES.
3385	01/01/1900	POS 21 22 23 NOT PAYABLE FOR FQHC/RHC PROVIDERS
3386	01/01/1900	MNTL HLTH MODIFIER HW RSTRN FOR TAXONOMY
3390	01/01/1900	PROVIDER NOT VFC ATTESTED FOR VACCINE OR ADMIN CODES
3391	01/01/1900	ROUTINE CIRCUMCISION NOT COVERED
3400	01/01/1900	MEDICAID COVERS ONE PREVENTIVE MEDICINE SERVICE FOR THE HEALTHY INDIVIDUAL EACHCALENDAR YEAR AGES 2 THROUGH 20. PAYMENT HAS ALREADY BEEN MADE FOR THIS CALENDAR YEAR.
3402	01/01/1900	MEDICAID COVERS ONE PREVENTIVE MEDICINE SERVICE FOR THE HEALTHY INDIVIDUAL EACHCALENDAR YEAR AGES 60 AND OVER. PAYMENT HAS ALREADY BEEN MADE FOR THIS CALENDAR YEAR.
3403	01/01/1900	MEDICAID COVERS ONE PREVENTIVE MEDICINE SERVICE FOR THE HEALTHY INDIVIDUAL EVERY 2 CALENDAR YEARS FOR AGES 50 THROUGH 59. PAYMENT HAS ALREADY BEEN MADE.
3405	01/01/1900	MEDICAID COVERS ONE PREVENTIVE MEDICINE SERVICE FOR THE HEALTHY INDIVIDUAL EVERY THREE CALENDAR YEARS FOR AGES 21 THROUGH 49. PAYMENT HAS ALREADY BEEN MADE.
3406	01/01/1900	MEDICAID COVERS ONE ROUTINE GYNECOLOGICAL EVALUATION FOR THE HEALTHY INDIVIDUALEACH CALENDAR YEAR. PAYMENT HAS ALREADY BEEN MADE FOR THIS CALENDAR YEAR.
3411	01/01/1900	DIAGNOSIS CODE NOT SPECIFIC
3452	01/01/1900	DISPENSE THE PREFERRED BRAND RATHER THAN THE NON-PREFERRED GENERIC. SEE PREFERRED DRUG LIST (PDL) AT HTTP://WWW.MEDICAID.MS.GOV/

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
3459	01/01/1900	HCBS NOT COVERED WHEN MEMBER IS IN A NURSING HOME
3460	01/01/1900	SERVICES NOT COVERED FOR LOCKIN MEMBER
3461	01/01/1900	CSP NOT ALLOWED FOR WED WIL WID WTB SED LOCKINS
3462	01/01/1900	THE BILLING AND RENDERING PROVIDER IS REQUIRED TO BE THE SAME PROVIDER.
3500	01/01/1900	MEDICAID COVERS THREE PREVENTIVE MEDICINE SERVICES FOR THE HEALTHY INDIVIDUAL BETWEEN THE FIRST AND SECOND BIRTHDAY. PAYMENT HAS ALREADY BEEN MADE FOR THREE VISITS.
3501	01/01/1900	MORE THAN 12 PHARMACOLOGIC MANAGEMENT SERVICES IN A STATE FISCAL YEAR REQUIRE PRIOR AUTHORIZATION FOR RECIPIENTS ENROLLED IN DIAMOND STATE PARTNERS.
3502	01/01/1900	MORE THAN FOUR BITEWING FILMS WITHIN SIX MONTHS REQUIRE ADDITIONAL DOCUMENTATION. RESUBMIT WITH NOTES TO DOCUMENT THE NEED FOR ADDITIONAL BITEWING FILMS.
3503	01/01/1900	MORE THAN ONE VISIT DONE ON THE SAME DAY BY THE SAME BILLING PROVIDER REQUIRESADDITIONAL DOCUMENTATION. RESUBMIT WITH OFFICE OR HOME VISIT NOTES FOR ALL VISITS.
3504	01/01/1900	ONE NEW PATIENT SERVICE PER 3 YEARS PER PROVIDER.
3505	01/01/1900	PART OR ALL OF THE UNITS BILLED EXCEED MAXIMUM ALLOWABLE LIMITS.
3507	01/01/1900	PROCEDURE IS ALLOWED ONE TIME IN 6 MONTHS AFTER COMPLETION OF PERIDONTAL SCALING. MUST NOT BE BILLED WITHIN 3 MONTHS OF PROPHYLAXIS.
3509	01/01/1900	PROPER RESOLUTION OF THIS CLAIM REQUIRES THE ASSOCIATED ER VISIT NOTES OR INPATIENT HOSPITAL DISCHARGE SUMMARY. PLEASE RESUBMIT WITH THIS DOCUMENTATION.
3580	01/01/1900	TPL - HMS LONG TERM CARE AUDITS (LTC)
3581	01/01/1900	TPL - HMS CREDIT BALANCE AUDITS (CBA)
3582	01/01/1900	TPL - HMS COMMERCIAL DISALLOWANCE
3583	01/01/1900	TPL - HMS MEDICARE DISALLOWANCE
3601	01/01/1900	PULP TREATMENT IS DISALLOWED WHEN ENDODONTIC TREATMENT IS COMPLETED ON SAME DAY.
3602	01/01/1900	QUANTITY LIMITS FOR MEDICATION CLASS HAVE BEEN EXCEEDED.
3603	01/01/1900	SERVICE COVERED ONE TIME IN TWO YEARS. YOU OR ANOTHER PROVIDER HAVE BEEN REIMBURSED FOR THIS SERVICE.
3604	01/01/1900	SERVICE IS LIMITED TO ONE TIME IN 5 YEARS. YOU OR ANOTHER PROVIDER HAVE BEEN PAID FOR THIS SERVICE.
3605	01/01/1900	SERVICE LIMITED TO ONE PER 365 DAYS. PAYMENT HAS ALREADY BEEN MADE TO YOU OR ANOTHER PROVIDER WITHIN 365 DAYS OF THIS DATE OF SERVICE.
3606	01/01/1900	SERVICE LIMITED TO ONE PER CALENDAR YEAR. PAYMENT HAS ALREADY BEEN MADE TO YOUOR ANOTHER PROVIDER FOR THIS CALENDAR YEAR.
3610	01/01/1900	SERVICE LIMITED TO ONE PER PROVIDER PER DAY.
3732	01/01/1900	DRG RESTRICTION ON REV CODE CVG RULE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
3801	01/01/1900	SERVICE ROUTINELY COVERED ONCE PER 365 DAYS. PAYMENT HAS ALREADY BEEN MADE. FORREVIEW OF MEDICAL NECESSITY RESUBMIT WITH FULL DOCUMENTATION.
3802	01/01/1900	SERVICE ROUTINELY COVERED ONCE PER SIX MONTHS. PAYMENT HAS ALREADY BEEN MADE TOYOU OR ANOTHER PROVIDER.
3803	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM ALREADY PAID TO YOU OR ANOTHER PROVIDER FOR MR WAIVER EMPLOYMENT OR DAY HABILITATION SERVICES.
3804	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM ALREADY PAID TO YOU OR ANOTHER PROVIDER FOR MR WAIVER RESIDENTIAL SERVICES.
3805	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM ALREADY PAID TO YOU OR ANOTHER PROVIDER FOR MR WAIVER RESPITE OR RESIDENTIAL SERVICES.
3808	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM ALREADY PAID TO YOUR FACILITY FOR INPATIENT SERVICES. ADJUST AS NECESSARY.
3809	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM ALREADY PAID TO YOUR FACILITY FOR OUTPATIENT SERVICES. ADJUST AS NECESSARY.
3810	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM ALREADY PAID TO YOUR FACILITY UNDER A DIFFERENT PROVIDER NUMBER.
3811	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM PREVIOUSLY SUBMITTED. ADJUST AS NECESSARY.
3812	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A HOME HEALTH CLAIM. REVIEW THE DATES OF SERVICE ON YOUR CLAIM.
3813	01/01/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A NURSING HOME CLAIM. REVIEW THE DATES OF SERVICE ON YOUR CLAIM.
3814	01/01/1900	THE DATES OF SERVICE ON YOUR CLAIM OVERLAP THE DATES OF SERVICE ON AN INPATIENTHOSPITAL CLAIM. REVIEW THE DATES OF SERVICE ON YOUR CLAIM. CALL HPES PROVIDERSERVICES WITH QUESTIONS.
3815	01/01/1900	THERAPEUTIC DUPLICATION.
3816	01/01/1900	THIS CLAIM HAS BEEN DETERMINED TO BE A DUPLICATE OF ANOTHER CLAIM WHICH HAS ALREADY BEEN PAID. IF YOU HAVE QUESTIONS, REFER TO YOUR PROVIDER MANUAL OR CALL GAINWELL TECHNOLOGIES PROVIDER SERVICES.
3817	01/01/1900	THIS CLAIM IS BEING DENIED AS A DUPLICATE BECAUSE YOU ARE BILLING MULTIPLE CROWNS FOR THE SAME TOOTH ON THE SAME DAY. REVIEW THE CODING SERIES AND ADJUST AS NECESSARY.
3818	01/01/1900	THIS CLAIM IS BEING DENIED AS A DUPLICATE BECAUSE YOU ARE BILLING MULTIPLE RESTORATIONS FOR THE SAME TOOTH ON THE SAME DAY. REVIEW THE CODING SERIES AND ADJUST AS NECESSARY.
3819	01/01/1900	THIS SERVICE IS COVERED ONE TIME IN 3 YEARS. THE FREQUENCY LIMIT HAS BEEN EXHAUSTED.
3820	01/01/1900	UNITS BILLED EXCEED MAX ALLOWED PER DAY.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
3821	01/01/1900	YOU ARE BILLING A COMPLETE INTRAORAL RADIOGRAPHIC SERIES WITHIN 30 DAYS OF PANORAMIC, PERIAPICAL OR BITEWING X-RAY.
3822	01/01/1900	YOU ARE BILLING AN ANCILLARY PROCEDURE WITHOUT A SURGICAL PROCEDURE ON THE SAMEDAY. THIS CLAIM WILL NOT BE PAID.
3823	01/01/1900	YOU ARE BILLING FOR A LABORATORY PANEL CODE AND YOU HAVE ALREADY BEEN PAID FORINDIVIDUAL COMPONENTS OF THE PANEL. VOID THE ORIGINAL CLAIM(S) AND RESUBMIT THEPANEL FOR PAYMENT.
3824	01/01/1900	YOU ARE BILLING FOR A THERAPY SERVICE FOR A NURSING HOME RESIDENT. ONLY THE NURSING HOME CAN BILL MEDICAID FOR THIS SERVICE. SUBMIT YOUR BILL TO THE NURSING HOME.
3825	01/01/1900	YOU ARE BILLING FOR MULTIPLE SURGICAL PROCEDURES ON THE SAME DAY. AN OPERATIVEREPORT IS REQUIRED IN ORDER TO DETERMINE THE PROPER PAYMENT.
3826	01/01/1900	YOUR CLAIM HAS EXCEEDED AN ALLOWED AMOUNT OF $500 . PLEASE VERIFY THE QUANTITYBILLED. IF CORRECT, PLEASE CONTACT HPES FOR PRIOR AUTHORIZATION.
3870	01/01/1900	AMBIEN 10 MG, EDLUAR 10 MG, AMBIEN CR 12.5 MG AND INTERMEZZO 3.5 MG ARE NOT RECOMMENDED FOR USE IN WOMEN. USE LOWER STRENGTH
3878	01/01/1900	THE PROCEDURE BILLED IS RESTRICTED BY LOCKIN PLAN
3892	01/01/1900	THE REVENUE NEEDS TO BE BILLED WITH ANOTHER REVENUE ON CLAIM.
3893	01/01/1900	THE PROCEDURE CODE REQUIRES AN APPROPRIATE CORRESPONDING REVENUE CODE ON THE SAME CLAIM.
3895	01/01/1900	THE PROCEDURE CODE REQUIRES AN APPROPRIATE CORRESPONDING REVENUE CODE ON THE SAME DETAIL.
3897	01/01/1900	THE REVENUE CODE BILLED HAS QUANTITY RESTRICTIONS
3899	01/01/1900	THE PROCEDURE CODE BILLED WITH THE REVENUE CODE IS INVALID OR MISSING.
3990	01/01/1900	TPL RESTRICTION ON PROC CVG RULE
3991	01/01/1900	NO CVG RULE FOR PROC VIA PROC GRP
3992	01/01/1900	TYPE OF BILL RESTRICTION ON REV CODE CVG RULE
3993	01/01/1900	TPL RESTRICTION ON REV CODE CVG RULE
3994	01/01/1900	ICD PROC GROUP RESTRICTION ON REV CVG RULE
4002	01/01/1900	MEMBER'S BENEFIT PACKAGE DOES NOT INCLUDE THIS MEDICATION.
4003	01/01/1900	PRODUCT NOT COVERED. (IF MEDICAL SUPPLY, SUBMIT PROFESSIONAL CLAIM.)
4004	01/01/1900	PRODUCT IS EITHER NOT COVERED OR AGE IS LESS THAN FDA APPROVED MIN AGE. IF AGE< 21, PRESCRIBER MAY SUBMIT PA MEDICAL NECESSITY REQUEST FOR EPSDT ELIGIBLE MEMBER. (IF MEDICAL SUPPLY, SUBMIT PROFESSIONAL CLAIM.)
4005	01/01/1900	IF AGE < 21, PRESCRIBER MAY SUBMIT PA MEDICAL NECESSITY REQUEST FOR EPSDT ELIGIBLE MEMBER.
4012	01/01/1900	Newly Released Drug. Contact the Gainwell Technologies Pharmacy Helpdesk for billing options.
4014	01/01/1900	NO PRICING ON FILE
4015	01/01/1900	NO PATIENT LIABILITY FOR DOS - RECYCLE

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
4016	01/01/1900	NO PATIENT LIABILITY FOR DOS - CONTACT REGIONAL OFFICE
4022	01/01/1900	NO DRUG COVERAGE UNDER MEMBER'S QUALIFIED MEDICARE BENEFICIARY (QMB) BENEFIT PLAN.
4032	01/01/1900	NO DRUG COVERAGE UNDER MEMBER'S SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) BENEFIT PLAN.
4052	01/01/1900	ADMIT DIAGNOSIS CODE IS NOT ON FILE.
4062	01/01/1900	PRINCIPAL ICD PROCEDURE CODE IS NOT COVERED
4063	01/01/1900	NON-COVERED ICD PROCS (1ST ICD PROC)
4064	01/01/1900	NON-COVERED ICD PROCS (ICD PROCS 2-24)
4074	01/01/1900	LABS ONLY ALLOW POS 11 22 23 32 50 51 71 72 81.
4075	01/01/1900	EPSDT SERVICES REQUIRE AGREEMENT OR ATTESTATION
4076	01/01/1900	THE COMBINED SUBMITTED UNITS FOR THE VACCINE ADMINISTRATION SERVICES MUST EQUALTHE COMBINED SUBMITTED UNITS FOR THE VACCINE SERVICES.
4080	01/01/1900	MEMBER EXCEEDS AGE FOR PEDIATRIC LTC HOSP
4082	01/01/1900	MEMBER DOES NOT MEET THE AGE RESTRICTION FOR INPATIENT/PRTF PSYCHIATRIC SERVICES.
4083	01/01/1900	PATIENT'S STATUS IS DISCHARGED.
4086	01/01/1900	WEEKEND PRTF ADMISSION NOT ALLOWED
4092	01/01/1900	CONSENT NOT APPROVED-STERIL, ABORTION AND HYST
4096	01/01/1900	MDC NOT ON FILE
4099	01/01/1900	DRG NOT ON FILE
4100	01/01/1900	DRG RATE RECORD NOT FOUND
4102	01/01/1900	HOSPICE LOCK-IN COUNTY NOT FOUND
4104	01/01/1900	PROVIDER DRG RATE RECORD NOT FOUND
4105	01/01/1900	UNABLE TO ASSIGN MCC FOR DRG PRICING
4106	01/01/1900	INVALID DRG INTERIM STAY PER DIEM
4107	01/01/1900	INVALID DRG COST OUTLIER PRICING DATA
4108	01/01/1900	COVERED DAYS ARE LESS THAN OR EQUAL TO INTERIM BILL THRESHOLD.
4109	01/01/1900	OUTPATIENT PER DIEM RATE NOT FOUND
4110	01/01/1900	DRG LONG STAY THRESHOLD WITHOUT PA
4140	01/01/1900	ANNUAL PHYSICAL EXAMS ARE NOT COVERED FOR FIRST YEAR
4141	01/01/1900	MEMBER'S DATE OF DEATH IS NOT ON FILE. DATE OF DEATH REQUIRED FOR REVENUE BILLED.
4142	01/01/1900	HOSPICE PATIENT STATUS IS EXPIRED BUT MEMBER'S DATE OF DEATH IS NOT ON FILE. SERVICE INTENSITY ADD-ON (SIA) NOT APPLIED.
4144	01/01/1900	HOSPICE SERVICE INTENSITY ADD-ON (SIA) NOT ALLOWED. SIA SERVICES NOT PERFORMEDWITHIN 7 DAYS OF THE MEMBER'S DATE OF DEATH ON FILE.
4145	01/01/1900	HOSPICE NF UNITS GREATER THAN TOTAL DAYS
4146	01/01/1900	MEMBER'S HOSPICE LOCK-IN COUNTY NOT REIMBURSABLE. CONTACT ALLIANT TO UPDATE THEHOSPICE PRECERTIFICATION FORM WITH MEMBER'S COUNTY WHERE HOSPICE SERVICES AREBEING PERFORMED.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
4148	01/01/1900	PATIENT DISCHARGE STATUS DOES NOT MEET BILLING RESTRICTIONS FOR THE REVENUE CODE BILLED.
4153	01/01/1900	ADMIT TYPE RESTRICTED FOR SERVICES BILLED.
4154	01/01/1900	DRG COVERED DAYS RESTRICTED FOR SERVICES BILLED.
4155	01/01/1900	SERVICE NOT COVERED WHEN BILLED BY AN OUTPATIENT HOSPITAL
4159	01/01/1900	THE SERVICE IS NOT REIMBURSABLE FOR THE PROVIDER'S CONTRACT.
4160	01/01/1900	DETAIL FDOS/TDOS SPANS MORE THAN ONE DAY
4189	01/01/1900	PROVIDER UCC RATE NOT FOUND
4190	01/01/1900	PROCEDURE MAX FEE RATE NOT FOUND
4191	01/01/1900	PROCEDURE/MODIFIER MAX FEE RATE NOT FOUND
4192	01/01/1900	ANESTHESIA RATE NOT FOUND
4193	01/01/1900	PROVIDER CLINIC RATE NOT FOUND
4194	01/01/1900	LTC Segment Not Found for Hospice Member - Recycle
4195	01/01/1900	LTC Segment Not Found for Hospice Member
4196	01/01/1900	Hospice LTC Per Diem Rate Not Found
4197	01/01/1900	LTC Per Diem Rate Not Found
4198	01/01/1900	PROVIDER REVENUE RATE NOT FOUND
4199	01/01/1900	REVENUE RATE NOT FOUND
4230	01/01/1900	MEDICARE DEDUCTIBLE SUBMITTED ON THE CLAIM IS GREATER THAN THE ANNUAL MEDICAREDEDUCTIBLE
4260	01/01/1900	PROC CODE GROUP RESTRICTION ON PROC CVG RULE
4261	01/01/1900	REV CODE GROUP RESTRICTION ON REV CVG RULE
4262	01/01/1900	LOCKIN REQUIRED FOR REVENUE CODE BILLING RULE
4264	01/01/1900	MEMBER LOCKIN PLAN RSTCN ON NDC CVG RULE
4265	01/01/1900	MEMBER LOCKIN PLAN RSTCN ON PROC CVG RULE
4267	01/01/1900	BILLING PROVIDER TAXONOMY RSTCN ON REV CVG RULE
4268	01/01/1900	MEMBER LOCKIN PLAN RSTCN ON REV CVG RULE
4346	01/01/1900	MEDICAL DEVICES NOT COVERED
4373	01/01/1900	NONPREFERRED GENERIC/ NO PA REQUIRED FOR PREFERRED BRAND
4502	01/01/1900	MEDICARE EOMB IS MISSING OR DOES NOT MATCH THE SERVICES ON THE CLAIM. RESUBMITTHE CLAIM WITH THE MEDICARE EOMB ATTACHED.
4503	01/01/1900	MEMBER IS ENROLLED IN MEDICARE PART C ON THE DATE(S) OF SERVICE.
4600	01/01/1900	PRIMARY DIAGNOSIS AND AGE CONFLICT
4602	01/01/1900	FIRST DIAGNOSIS/AGE CONFLICT
4603	01/01/1900	SECOND DIAGNOSIS/AGE CONFLICT
4604	01/01/1900	THIRD DIAGNOSIS/AGE CONFLICT
4605	01/01/1900	FOURTH DIAGNOSIS/AGE CONFLICT
4606	01/01/1900	FIFTH DIAGNOSIS/AGE CONFLICT
4607	01/01/1900	DIAGNOSIS CODE 6-24 AGE CONFLICT
4608	01/01/1900	NO GENDER MATCH FOR DIAGNOSIS CODE
4610	01/01/1900	FIRST DIAGNOSIS/GENDER CONFLICT
4611	01/01/1900	SECOND DIAGNOSIS/GENDER CONFLICT

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
4612	01/01/1900	THIRD DIAGNOSIS/GENDER CONFLICT
4613	01/01/1900	FOURTH DIAGNOSIS/GENDER CONFLICT
4614	01/01/1900	FIFTH DIAGNOSIS/GENDER CONFLICT
4615	01/01/1900	DIAGNOSIS CODE 6 -24 GENDER CONFLICT
4616	01/01/1900	PRINCIPLE ICD SURGICAL PROCEDURE CODE/GENER CNFL
4617	01/01/1900	1ST ICD SURGICAL PROCEDURE/GENDER CONFLICT
4618	01/01/1900	ICD SURGICAL PROCEDURE CODES IN ONE OR MORE POSITIONS 3-24 HAS A GENDER CONFLICT
4619	01/01/1900	ICD9 CODES WITH DATES OF SERVICE AFTER ICD10 CUTOVER
5000	01/01/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5001	01/01/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM
5002	01/01/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5003	01/01/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5004	01/01/2014	THIS DETAIL IS BEING PAID AND THE SAME DRUG WITH OVERLAPPING DATES IS BEING RECOUPED ON A MEDICAL CLAIM.
5005	01/01/1900	INPATIENT SERVICES PERFORMED THREE DAYS AFTER OUTPATIENT DATE OF SERVICE
5006	01/01/2014	OUTPATIENT SERVICES PERFORMED THREE DAYS PRIOR TO INPATIENT ADMISSION.
5007	01/01/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5008	01/01/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5009	01/01/1900	WAIVER SERVICE NOT PAYABLE WITH INPATIENT SERVICE WITH OVERLAPPING DATES OF SERVICE. PLEASE REVIEW SERVICES PROVIDED AND RESUBMIT THE CLAIM WITH ACCURATE DATES OF SERVICE
5010	01/01/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5011	01/01/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5013	01/01/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5014	01/01/1900	A PHARMACY CLAIM WITH THE SAME DRUG IS PAID WITH OVERLAPPING DATES OF SERVICE.
5020	01/01/2014	THIS IS A SUSPECT DUPLICATE OF ANOTHER CLAIM.
5021	01/01/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5022	01/01/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5023	01/01/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM FILLED BY A DIFFERENT PROVIDER.
5024	01/01/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5026	01/01/2014	SUSPECT WAIVER SERVICE DURING INPATIENT STAY.
5027	01/01/1900	THE INPATIENT SERVICE IS PAID AND A WAIVER SERVICE FOR OVERLAPPING DATES OF SERVICE IS BEING RECOUPED.
5028	01/01/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5030	01/01/2014	THIS IS A SUSPECT DUPLICATE OF ANOTHER CLAIM.
5031	01/01/1900	THIS IS A SUSPECT DUPLICATE OF ANOTHER CLAIM.
5032	01/01/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5033	01/01/1900	THIS IS A SUSPECT DUPLICATE OF ANOTHER CLAIM.
5040	01/01/1900	Leave Days are greater than Total Days Billed

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5050	01/01/2014	A SURGICAL PROCEDURE CODE FOR THE SAME PHYSICIAN FOR THE SAME DATE OF SERVICE HAS BEEN PREVIOUSLY PAID.
5056	01/01/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5100	01/01/1900	Encounters vs Encounters Exact Dupe
5102	01/01/1900	CHIP Encounters vs CHIP Encounters Exact Dupe
5104	01/01/1900	NET Encounter Transportation Exact Dupe
5110	01/01/1900	Pharmacy vs Pharmacy Exact Dupe
5111	01/01/1900	Pharmacy vs Pharmacy Suspect Dupe
5115	01/01/1900	THE CUMULATIVE MME FOR THE REQUESTED LONG ACTING OPIOID RX PLUS ALL OTHER ACTIVE OPIOID PRESCRIPTIONS IS >/= 90 MME PER DAY WHICH REQUIRES A CLINICAL PA FOR APPROVAL.
5116	01/01/1900	THE CUMULATIVE MME FOR THE REQUESTED SHORT ACTING OPIOID RX PLUS ALL OTHER ACTIVE OPIOID PRESCRIPTIONS IS > OR EQUAL TO 90 MME PER DAY WHICH REQUIRES A CLINICAL PA FOR APPROVAL.
5200	01/01/1900	ROUTINE POST-OPERATIVE MEDICAL VISITS ARE NOT SEPARATELY PAYABLE.
5201	01/01/1900	SURGICAL SERVICES AND ROUTINE PREOPERATIVE MEDICAL VISITS ARE NOT SEPARATELY PAYABLE. A PREVIOUSLY PAID ROUTINE PREOPERATIVE MEDICAL VISIT IS BEING RECOUPED.
5202	01/01/1900	ROUTINE POST-OPERATIVE MEDICAL VISITS ARE NOT SEPARATELY PAYABLE. THE SURGICALSERVICE WILL BE SET TO PAY AND THE E&M SERVICE WILL BE DENIED.
5320	01/01/1900	PRIOR TO 07/01/2019 PHYSICIAN OFFICE VISITS LIMITED TO 12 PER STATE FISCAL YEAR.
5385	01/01/1900	PRIOR TO 07/01/2019 PSYCHIATRIC OFFICE VISITS LIMITED TO 12 PER STATE FISCAL YEAR
5500	01/01/2014	FAMILY PLANNING WAIVER OUTPATIENT OFFICE VISITS LIMITED TO 4 PER CALENDAR YEAR
5501	01/01/1900	DENTAL SERVICES ARE LIMITED TO $2500 PER FISCAL YEAR.
5502	01/01/2014	NURSING HOME LEAVE OF ABSENCE DAYS LIMITED TO 58 DAYS PER STATE FISCAL YEAR
5504	01/01/2014	DENTAL ORAL EXAMS ARE LIMITED TO TWO PER STATE FISCAL YEAR.
5505	01/01/1900	INTERMEDIATE CARE FACILITY LEAVE OF ABSENCE DAYS LIMITED TO 90 DAYS PER STATE FISCAL YEAR
5506	01/01/2014	PSYCHIATRIC RESIDENTIAL TREATMENT CENTER LEAVE OF ABSENCE DAYS LIMITED TO 90 DAYS PER STATE FISCAL YEAR
5507	01/01/1900	PERIODIC ORAL EVALUATION IS LIMITED TO ONE PER SIX MONTHS.
5508	01/01/1900	DENTAL PROCEDURE D0150 LIMITED TO 1 PER 36 MONTHS BY SAME PROVIDER.
5509	01/01/1900	CHIROPRACTIC SERVICES LIMITED TO $700 PER STATE FISCAL YEAR.
5510	01/01/1900	DENTAL ORAL EVALUATIONS ARE LIMITED TO 4 PER STATE FISCAL YEAR.
5511	01/01/1900	PSYCHIATRIC THERAPEUTIC LEAVE DAYS LIMITED TO 18 PER STATE FISCAL YEAR.
5512	01/01/2014	PERIODONTAL SERVICES LIMITED TO ONE PER AREA OF ORAL CAVITY PER 2 STATE FISCALYEARS.
5513	01/01/1900	PROPHYLAXIS SERVICE LIMITED TO TWO PER STATE FISCAL YEAR
5514	01/01/2014	FLUORIDE SERVICE LIMITED TO TWO PER STATE FISCAL YEAR.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5515	01/01/1900	THE CUMULATIVE MME FOR THE REQUESTED LONG ACTING OPIOID RX PLUS ALL OTHER ACTIVE OPIOID PRESCRIPTIONS IS >/= 90 MME PER DAY WHICH REQUIRES A MANUAL PA FOR APPROVAL.
5516	01/01/2014	LENS LIMIT EXCEEDED.
5517	01/01/1900	EYEGLASS FRAMES LIMITED TO 2 PER STATE FISCAL YEAR
5518	01/01/2014	HOME HEALTH DAYS LIMITED TO 36 DAYS PER STATE FISCAL YEAR.
5520	01/01/2014	PHYSICIAN OFFICE VISITS LIMITED TO 16 PER STATE FISCAL YEAR.
5524	01/01/2014	PHYSICIAN LONG TERM CARE VISITS LIMITED TO 36 PER STATE FISCAL YEAR.
5525	01/01/1900	HEARING AID SERVICE LIMIT EXCEEDED
5526	01/01/2014	LENS LIMIT EXCEEDED.
5527	01/01/1900	PHARMACY DISEASE MANAGEMENT COUNSELING SERVICES LIMITED TO 12 SESSIONS PER STATE FISCAL YEAR
5532	01/01/2014	MENTAL HEALTH ASSESSMENT OR EVALUATION SERVICE LIMITED TO 4 PER STATE FISCAL YEAR.
5533	01/01/1900	MENTAL HEALTH ASSERTIVE COMMUNITY TREATMENT SERVICE LIMITED TO 1600 PER YEAR
5534	01/01/2014	MENTAL HEALTH CRISIS RESPONSE SERVICE LIMITED TO 224 PER STATE FISCAL YEAR.
5535	01/01/1900	MENTAL HEALTH COMMUNITY SUPPORT SERVICE LIMITED TO 400 PER STATE FISCAL YEAR
5536	01/01/2014	MENTAL HEALTH PEER SUPPORT SERVICE LIMITED TO 200 PER STATE FISCAL YEAR.
5537	01/01/1900	MENTAL HEALTH WRAPAROUND SERVICE LIMITED TO 200 PER STATE FISCAL YEAR
5538	01/01/2014	MENTAL HEALTH PLAN DEVELOPMENT SERVICE LIMITED TO 4 PER STATE FISCAL YEAR.
5539	01/01/1900	MENTAL HEALTH PSYCHOLOGICAL EVALUATION SERVICES LIMITED TO 8 PER STATE FISCAL YEAR
5540	01/01/2014	MENTAL HEALTH CRISIS RESIDENTIAL SERVICE LIMITED TO 60 PER STATE FISCAL YEAR.
5541	01/01/1900	MENTAL HEALTH INTENSIVE OUTPATIENT PSYCHIATRIC SERVICE LIMITED TO 270 PER STATEFISCAL YEAR
5542	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT, HETLIOZ LIQ LIMITED TO 48ML IN 31 DAYS, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5543	01/01/1900	RESPITE WAIVER CARE SERVICES LIMITED TO 30 DAYS PER STAY
5544	01/01/2014	HOME AND COMMUNITY BASED SERVICE - RESPITE SERVICE LIMITED TO 240 UNITS PER CALENDAR MONTH.
5545	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT, HETLIOZ LIQ LIMITED TO 158ML IN 31 DAYS, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5550	01/01/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE.
5551	01/01/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE.
5552	01/01/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE.
5553	01/01/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5559	01/01/1900	ALCOHOL WIPES BOXES ARE LIMITED TO 2 PER MONTH
5560	01/01/2014	URINE TEST AND REAGANT STRIPS/TABLETS ARE LIMITED TO 1 PER MONTH.
5561	01/01/1900	BLOOD GLUCOSE TEST AND REAGANT STRIPS ARE LIMITED TO 4 PER MONTH
5562	01/01/2014	BLOOD GLUCOSE TESTING CALIBRATOR IS LIMITED TO 1 PER MONTH.
5563	01/01/1900	SPRING-POWERED LANCETS LIMITED TO 1 PER MONTH
5564	01/01/2014	LANCETS LIMITED TO 2 PER MONTH.
5566	01/01/2014	EYEGLASS FRAMES LIMITED TO 1 PER 12 MONTHS.
5567	01/01/1900	ESRD SERVICE LIMITED TO ONE PER CALENDAR MONTH
5569	01/01/1900	ANTIGEN SERVICES LIMITED TO 2 CLAIMS PER 45 DAYS
5570	01/01/2014	ROUTINE FOOT CARE WITH SYSTEMIC CONDITIONS LIMITED TO ONCE PER 60 DAYS
5571	01/01/1900	CARDIOVASCULAR DEVICE MONITORING SERVICES LIMITED TO ONCE PER 30 DAYS
5572	01/01/2014	CARDIOVASCULAR DEVICE MONITORING SERVICES LIMITED TO ONCE PER 90 DAYS
5575	01/01/1900	VISION SERVICE LIMITED TO 2 PER DATE OF SERVICE
5576	01/01/2014	SERVICES ARE LIMITED TO FIVE PER DAY.
5577	01/01/2014	CHOCTAW VISION E&M SERVICES ARE LIMITED TO ONE PER DAY.
5578	01/01/2014	CORE SERVICE ENCOUNTERS ARE LIMITED TO ONE PER DATE OF SERVICE.
5579	01/01/1900	INPATIENT CONSULTATIONS LIMITED TO ONE PER PROVIDER PER DAY
5580	01/01/2014	FRAMES LIMITED TO ONCE PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY.
5581	01/01/1900	CUSTOMER IS ALLOWED ONLY FIVE REFILLS PER PRESCRIPTION NUMBER
5582	01/01/2014	HOSPICE ROOM & BOARD SERVICES LIMITED TO ONE PER DAY PER CALENDAR MONTH
5583	01/01/1900	HOSPITAL VISITS LIMITED TO TWO PER DAY
5584	01/01/2014	HOSPITAL VISIT LIMITED TO ONE PER DAY
5585	01/01/1900	SEALANT LIMITED TO 1 PER TOOTH PER 5 ROLLING YEARS
5586	01/01/2014	DENTAL FULL MOUTH X-RAYS LIMITED TO ONE PER ROLLING 2 YEARS
5587	01/01/1900	INCONTINENT GARMENTS LIMITED TO 6 PER DAY.
5588	01/01/2014	ROOT CANAL LIMITED TO ONCE PER LIFETIME PER TOOTH.
5589	01/01/1900	DENTAL FILMS LIMITED TO 6 PER DAY
5590	01/01/2014	PRIMARY PULPOTOMY LIMITED TO 1 PER TOOTH PER LIFETIME.
5591	01/01/1900	DENTAL SCREENINGS AND EXAMS ARE LIMITED TO ONE PER DATE OF SERVICE PER PROVIDER
5592	01/01/2014	ORTHODONTIC SERVICES ARE LIMITED TO $4200 DURING THE MEMBER?S LIFETIME.
5593	01/01/1900	RESPITE CARE SERVICE T1005 LIMITED TO ONCE PER 365 DAYS
5594	01/01/2014	OFFICE VISITS ARE LIMITED TO ONE PER DAY PER PROVIDER .
5595	01/01/1900	SERVICE LIMITED TO ONCE PER LIFETIME
5596	01/01/2014	DME RENTAL LIMITED TO ONE PER 30 DAYS.
5597	01/01/1900	EYE EXAM/REFRACTION LIMITED TO 1 PER STATE FISCAL YEAR

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5598	01/01/2014	CASE MANAGEMENT FEE SERVICES LIMITED TO ONCE PER CALENDAR MONTH
5599	01/01/1900	SEDATIVE HYPNOTICS ARE LIMITED TO 2 PER 365 DAYS.
5600	01/01/2014	POST-PARTUM VISITS LIMITED TO 2 PER 9 MONTHS.
5601	01/01/1900	SHORT ACTING OPIOID PRESCRIPTIONS ARE LIMITED TO A MAXIMUM OF 1 7-DAY SUPPLIESIN A 30 DAY PERIOD.
5602	01/01/2014	SONOGRAM SERVICES LIMITED TO 3 PER 9 MONTHS.
5603	01/01/1900	THERAPY SERVICES ARE LIMITED TO 1 PER CALENDAR MONTH
5604	01/01/2014	NEWBORN VISITS ARE LIMITED TO 1 PER 9 MONTHS.
5605	01/01/1900	NURTEC ODT LIMITED TO 1 BOX (8 TABLETS) PER 22 DAYS. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE CLINICAL PA REQUEST IF GREATER QTY NEEDED.
5606	01/01/2014	UBRELVY LIMITED TO 16 TABLETS PER 22 DAYS. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE CLINICAL PA REQUEST IF GREATER QTY NEEDED.
5607	01/01/1900	FAMILY THERAPY SERVICE LIMITED TO 1 PER DAY
5608	01/01/2014	GROUP THERAPY SERVICES LIMITED TO 1 PER DAY.
5609	01/01/1900	CASE MANAGEMENT VISITS ARE LIMITED TO 1 PER DAY
5611	01/01/1900	FLUORIDE SERVICES ALLOWED ONCE IN A 5 MONTH PERIOD
5613	01/01/1900	PROPHYLAXIS SERVICES ALLOWED ONCE IN A 5 ROLLING MONTH PERIOD
5614	01/01/2014	T2022 LIMITED TO 1 PER MONTH
5615	01/01/1900	H2011 LIMITED TO 32 UNITS PER DAY
5616	01/01/2014	SERVICES LIMITED TO 260 UNITS PER 180 DAYS
5617	01/01/1900	SERVICES LIMITED TO 300 UNITS PER 30 DAYS
5618	01/01/2014	SERVICES LIMITED TO 300 UNITS PER 210 DAYS.
5619	01/01/1900	PROCEDURES G0396 AND G0397 LIMITED TO 1 PER 8 MONTHS
5620	01/01/2014	35 DAYS OF THERAPY WITH XARELTO 10 MG, PRADAXA 110 MG OR ELIQUIS IS ALLOWED. DAYS OF THERAPY ON THE INCOMING CLAIM PLUS THERAPY IN PRESECRIPTION HISTORY EXCEEDS 35 DAYS.
5621	01/01/1900	ZOLPIMIST CANISTERS LIMITED TO 1 PER 25 DAYS
5622	01/01/2014	FEMALE BENEFICIARIES ARE LIMITED TO 1 CANISTER OF ZOLPIMIST PER 51 DAYS.
5623	01/01/1900	TRIAZOLAM IS LIMITED TO 10 CUMULATIVE UNITS IN THE PAST 25 DAYS. QUANTITY ON CLAIM PLUS PRESCRIPTION HISTORY EXCEEDS THIS AMOUNT
5624	01/01/2014	TRIAZOLAM IS LIMITED TO A CUMMULATIVE DAYS SUPPLY OF 60 UNITS PER 365 DAYS. QUANTITY ON CLAIM PLUS PRESCRIPTION HISTORY EXCEEDS THIS AMOUNT.
5625	01/01/1900	SEDATIVE HYPNOTICS ARE LIMITED TO 31 CUMULATIVE TOTAL UNITS IN 25 DAYS. QUANTITY ON THE INCOMING CLAIM PLUS PRESCRIPTION HISTORY EXCEEDS THIS AMOUNT
5628	01/01/1900	HOME HEALTH EXTENDED DAYS ARE BILLABLE AFTER 36 DAYS ARE PAID. LESS THAN 36 HOME HEALTH VISITS HAVE BEEN PAID FOR THE STATE FISCAL YEAR.
5629	01/01/1900	REQUESTED LONG ACTING OPIOID PRESCRIPTION IS > OR EQUAL TO 90 MME PER DAY. OPIOID PRESCRIPTIONS FOR > 90 MME PER DAY REQUIRE A CLINICAL PA ONLY FOR APPROVAL.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5630	01/01/2014	PHARMACY HISTORY INDICATES PATIENT IS CURRENTLY ON A BENZODIAZEPINE. CONCOMITANT USE OF A LONG ACTING OPIOID AND A BENZODIAZEPINE IS CONTRAINDICATED AND REQUIRES A MANUAL PA FOR APPROVAL.
5634	01/01/2014	NEW SHORT ACTING OPIOID PRESCRIPTIONS ARE LIMITED TO A MAXIMUM 7-DAY SUPPLY. REQUESTED SHORT ACTING OPIOID RX FOR > 7-DAY SUPPLY EXCEEDS THIS LIMIT.
5636	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR DYNAVEL XR, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5639	01/01/1900	REQUESTED SHORT ACTING OPIOID PRESCRIPTION IS > 90 MME PER DAY. OPIOID PRESCRIPTIONS FOR > 90 MME PER DAY REQUIRE A CLINICAL PA ONLY FOR APPROVAL.
5640	01/01/2014	NUMBER OF REFILLS EXCEEDS ALLOWED AMOUNT FOR THIS RX NUMBER
5641	01/01/1900	REFILL LIMIT EXCEEDED FOR PRESCRIPTION NUMBER
5643	01/01/1900	SUBMITTED UNITS EXCEEDS MAX ALLOWED FOR CALENDAR MONTH. PRESCRIBER MAY SUBMIT PA REQUEST FOR GREATER QUANTITY
5644	01/01/2014	HOME AND COMMUNITY BASED SERVICE - RESPITE SERVICE LIMITED TO 96 UNITS PER DAY
5646	01/01/1900	ADULT DAY CARE SERVICES LIMITED TO 16 PER DAY.
5648	01/01/1900	PSYCHOSOCIAL REHABILITATION SERVICES LIMITED TO 5 HOURS PER DAY.
5649	01/01/1900	BEHAVIORAL HEALTH DAY TREATMENT SERVICES LIMITED TO 5 HOURS PER DAY.
5650	01/01/2014	ONLY THE FIRST 20 DAYS OF A NURSING HOME STAY ARE COVERED.
5655	01/01/1900	ONE TABLET SPLITTING DEVICE ALLOWED PER YEAR. CLAIMS HISTORY INDICATES A HISTORY OF ANOTHER TABLET SPLITTING DEVICE IN THE PAST 365 DAYS
5660	01/01/1900	ALVELOPLASTY EXTRACTION NOT PAYABLE WHEN LESS THAN 3 TEETH ARE EXTRACTED PER QUADRANT.
5663	01/01/1900	CTP PROCEDURE T1016 LIMITED TO 32 UNITS PER DAY
5664	01/01/2014	CTS PROCEDURE T1016 LIMITED TO 32 UNITS PER DAY.
5665	01/01/1900	TINT PROCEDURES LIMITED TO 2 PER 5 ROLLING YEARS
5666	01/01/2014	EYE GLASSES FITTING LIMITED TO ONCE PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY.
5667	01/01/1900	One Pair of lenses per 5yrs/6 MOS surgery
5668	01/01/2014	PREGNANCY PROCEDURES H0023 AND S9470 LIMITED TO 8 PER 9 MONTHS
5669	01/01/1900	PREGNANCY PROCEDURES S9470, S9123 AND S9127 LIMITED TO 5 PER 9 MONTHS
5670	01/01/2014	EEPSDT COUNSELING OR SCREENING SERVICES LIMITED TO 1 PER STATE FISCAL YEAR.PSDTCounseling/Screening service Lim to 1 SFY
5681	01/01/1900	MENTAL HEALTH INDIVIDUAL THERAPY SERVICES LIMITED TO 36 PER STATE FISCAL YEAR
5682	01/01/2014	MENTAL HEALTH FAMILY THERAPY SERVICES LIMITED TO 24 PER STATE FISCAL YEAR.
5683	01/01/1900	MENTAL HEALTH GROUP THERAPY SERVICES LIMITED TO 40 PER STATE FISCAL YEAR.
5684	01/01/2014	MENTAL HEALTH CASE MANAGEMENT SERVICES LIMITED TO 260 PER STATE FISCAL YEAR.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5685	01/01/1900	PSYCHIATRIC OFFICE VISITS LIMITED TO 16 PER STATE FISCAL YEAR
5686	01/01/2014	MENTAL HEALTH ACUTE PARTIAL HOSPITAL SERVICES LIMITED TO 100 PER STATE FISCAL YEAR.
5687	01/01/1900	NURSING ASSESSMENT SERVICES LIMITED TO 144 PER STATE FISCAL YEAR
5688	01/01/2014	MENTAL HEALTH EPSDT INDIVIDUAL SERVICE LIMITED TO 36 PER STATE FISCAL YEAR.
5689	01/01/1900	MENTAL HEALTH EPSDT FAMILY SERVICES LIMITED TO 24 PER STATE FISCAL YEAR
5690	01/01/2014	MENTAL HEALTH EPSDT GROUP SERVICES LIMITED TO 40 PER STATE FISCAL YEAR.
5695	01/01/1900	SYSTEM NOTIFICATION - DISPENSING FEE HAS BEEN PAID ON A PREVIOUS CLAIM DURING THE CALENDAR MONTH. DO NOT APPLY A DISPENSING FEE IN THE FINAL PRICING OF THIS CLAIM
5696	01/01/1900	SYSTEM NOTIFICATION - VACCINE ADMINISTRATION FEE HAS BEEN PAID ON A PREVIOUS CLAIM FOR THE SAME DATE OF SERVICE. DO NOT APPLY A ANOTHER VACCINE ADMINISTRATIONFEE IN THE FINAL PRICING OF THIS CLAIM.
5700	01/01/2014	HYDROCODONE TABS/CAPS ARE LIMITED TO 62 TOTAL CUMULATIVE UNITS OF ALL/ANY STRENGTHS IN THE PAST 31 ROLLING DAYS. IF HIGHER QTY NEEDED, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO DOM FOR A CLINICAL PA ONLY UNIT.
5701	01/01/1900	HYDROCODONE LIQUID LIMITED TO 480 TOTAL CUMULATIVE MILLILITERS OF ALL/ANY STRENGTHS PER MONTH. IF HIGHER QTY NEEDED, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TODOM FOR A CLINICAL PA ONLY UNIT.
5702	01/01/2014	INSULIN LIMITED TO 60 TOTAL CUMULATIVE MILLILITERS PER MONTH. IF HIGHER QTY NEEDED, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO DOM PA UNIT.
5703	01/01/1900	HYOSCYAMINE LIMITED TO 15 ML PER MONTH
5704	01/01/2014	OXYCODONE SHORT ACTING TABS/CAPS LIMITED TO 62 TOTAL CUMULATIVE UNITS OF ALL/ANY STRENGTHS IN THE PAST 31 ROLLING DAYS. MUST SUBMIT MAX UNIT OVERRIDE REQUESTTO DOM PA UNIT.
5705	01/01/1900	OXYCODONE LIQUID LIMITED TO 180 TOTAL CUMULATIVE ML. OF ALL/ANY STRENGTHS IN THE PAST 31 ROLLING DAYS. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST IF HIGHER QTY IS NEEDED
5706	01/01/2014	SEDATIVE-HYPNOTIC AGENTS ARE LIMITED TO 31 CUMULATIVE UNITS OF ALL/ANY STRENGTHS IN THE PAST 31 ROLLING DAYS. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE REQUESTIF HIGHER QTY NEEDED.
5707	01/01/1900	ANXIOLYTIC AGENTS ARE LIMITED TO 62 TOTAL CUMULATIVE UNITS OF ALL/ANY STRENGTHSIN THE PAST 31 ROLLING DAYS. MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO DOM PA UNIT
5710	01/01/2014	CARISOPRODOL TABLETS LIMITED TO 84 PER 6 MONTHS. THE QUANTITY ON THE CLAIM PLUSPRESCRIPTION HISTORY EXCEEDS THE QUANTITY LIMIT FOR CARISOPRODOL.
5711	01/01/1900	DRUG MUST HAVE OPIOID PRESCRIPTION IN PAST 30 DAYS.
5712	01/01/1900	NIMODIPINE IS LIMITED TO 252 CAPSULES PER MAXIMUM 21 DAYS OF THERAPY. QUANTITYON THE INCOMING CLAIM PLUS HISTORY IN THE PAST 21 DAYS EXCEEDS QUANTITY ALLOWED
5713	01/01/1900	ONZETRA LIMITED TO 1 BOX / 16 UNITS PER MONTH

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5715	01/01/1900	NIMODIPINE IS LIMITED TO 2520 ML PER MAXIMUM 21 DAYS OF THERAPY. QUANTITY ON THE INCOMING CLAIM PLUS HISTORY IN THE PAST 21 DAYS EXCEEDS QUANTITY ALLOWED.
5716	01/01/2014	B2I PRESCRIPTIONS LIMITED TO 8 PER MONTH. IF HIGHER QTY NEEDED, MUST SUBMIT MAXUNIT OVERRIDE REQUEST TO DOM PA UNIT.
5717	01/01/1900	BRAND LIMIT OF 5 PER MONTH EXCEEDED
5718	01/01/2014	BRAND LIMIT OF 5 PER MONTH EXCEEDED.
5720	01/01/2014	B2I PRESCRIPTIONS LIMITED TO 8 PER MONTH. IF HIGHER QTY NEEDED, MUST SUBMIT MAXUNIT OVERRIDE REQUEST TO DOM PA UNIT.
5721	01/01/1900	THE TOTAL NUMBER OF BRAND DRUGS FOR THIS MEMBER EXCEEDS THE 2 BRAND LIMIT PER CALENDAR MONTH
5725	01/01/1900	IMITREX LIMITED TO 2 TOTAL CUMULATIVE MILLILITERS PER 23 DAYS. IF HIGHER QTY NEEDED, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO DOM PA UNIT
5728	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR QUILLIVANT XR, MUST SUBMIT MAX UNIT OVERRIDEREQUEST TO A CLINICAL PA ONLY UNIT.
5729	01/01/1900	CHANTIX 1 MG CONT MONTH PAK LIMITED TO 56 UNITS IN 21 DAYS
5732	01/01/2014	RX EXCEEDS MONTHLY BRAND LIMIT OF 2. ADDITIONAL BRANDS ALLOWED FOR AGE < 21. PRESCRIBER MAY SUBMIT MEDICAL NECESSITY PA FORM FOR EPSDT ELIGIBLE MEMBER.
5733	01/01/1900	RX EXCEEDS MONTHLY LIMIT. ADDITIONAL PRESCRIPTIONS ALLOWED FOR BENEFICIARIES UNDER AGE 21 WITH PRIOR AUTHORIZATION.
5734	01/01/2014	RX EXCEEDS MONTHLY LIMIT.
5735	01/01/1900	MORE THAN TWO 72 HOUR EMERGENCY FILLS ATTEMPTED FOR THIS DRUG/STRENGTH THIS MONTH
5740	01/01/2014	HOSPITAL LEAVE DAYS ARE NOT PAYABLE WHEN 15 OR MORE HOSPITAL LEAVE DAYS HAVE ALREADY BEEN PAID.
5741	01/01/1900	LEAVE DAYS ARE NOT PAYABLE WHEN 15 OR MORE NURSING HOME LEAVE DAYS HAVE ALREADYBEEN PAID
5744	01/01/1900	HOSPICE SERVICES HAVE BEEN PAID FOR THE SAME MONTH ON A DIFFERENT CLAIM. HOSPICE SERVICES MUST BE BILLED ON THE SAME CLAIM FOR THE CALENDAR MONTH. PLEASE ADJUST THE PREVIOUSLY PAID CLAIM TO INCLUDE ALL SERVICES FOR THE MONTH.
5745	01/01/1900	RESPITE CARE DAYS ARE LIMITED TO 5 CONSECUTIVE DAYS.
5746	01/01/1900	HOSPICE SERVICE INTENSITY ADD-ONS LIMITED TO 16 UNITS PER DAY.
5750	01/01/1900	PHARM Only 1 Disp Fee Per Drug Per Month
5755	01/01/1900	THE MAXIMUM RECOMMENDED DOSE OF CITALOPRAM FOR PATIENTS MORE THAN 18 YEARS OF AGE AND LESS THAN 59 YEARS OF AGE IS 40 MG PER DAY. DOSE ON CLAIM EXCEEDS 40 MG.
5756	01/01/1900	THE MAXIMUM RECOMMENDED DOSE OF CITALOPRAM FOR PATIENTS 60 YEARS OF AGE AND OLDER IS 20 MG PER DAY. DOSE ON CLAIM EXCEEDS 20 MG.
5760	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5761	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA REQUEST FOR GREATER QUANTITIES.
5762	01/01/1900	ORAL INHALER CUMULATIVE ROLLING MONTHLY QUANTITY LIMIT OF 17 GRAMS EXCEEDED.
5763	01/01/1900	ORAL INHALER CUMULATIVE ROLLING MONTHLY QUANTITY LIMIT OF 13.4 GRAMS EXCEEDED.
5764	01/01/1900	ORAL INHALER CUMULATIVE ROLLING MONTHLY QUANTITY LIMIT OF 16 GRAMS EXCEEDED.
5765	01/01/1900	ORAL INHALER CUMULATIVE ROLLING MONTHLY QUANTITY LIMIT OF 36 GRAMS EXCEEDED.
5769	01/01/1900	BOTOX INJECTION SERVICES LIMITED EXCEEDED PER 90 DAYS
5770	01/01/2014	BOTOX INJECTION SERVICES LIMITED EXCEEDED PER 90 DAYS.
5771	01/01/1900	BOTOX INJECTION SERVICES LIMITED EXCEEDED PER 90 DAYS
5772	01/01/2014	BOTOX INJECTION SERVICES LIMITED EXCEEDED PER 90 DAYS.
5775	01/01/1900	A QTY OF MORE THAN 3 SYRINGES PER YEAR REQUIRES A CLINICAL PA.
5776	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO CLINICAL PA ONLY UNIT.
5778	01/01/1900	EPSDT SCREENING LIMITED TO ONE.
5779	01/01/1900	EPSDT SCREENING LIMITED TO ONE.
5780	01/01/2014	EPSDT SCREENING LIMITED TO ONE.
5781	01/01/1900	EPSDT SCREENING LIMITED TO ONE
5782	01/01/2014	EPSDT SCREENING LIMITED TO ONE.
5783	01/01/1900	EPSDT SCREENING LIMITED TO ONE
5784	01/01/2014	EPSDT SCREENING LIMITED TO ONE.
5785	01/01/1900	EPSDT SCREENING LIMITED TO ONE
5786	01/01/2014	EPSDT SCREENING LIMITED TO ONE.
5787	01/01/1900	EPSDT SCREENING LIMITED TO ONE
5788	01/01/1900	EPSDT SCREENING LIMITED TO ONE.
5789	01/01/1900	Physical Assessment - 99382 99392 - 30 Months
5791	01/01/1900	PHYSICAL ASSESSMENT LIMITED TO ONE PER STATE FISCAL YEAR
5792	01/01/2014	REYVOW 50 MG LIMITED TO 4 TABLETS PER 25 DAYS. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5793	01/01/1900	REYVOW 100 MG LIMITED TO 8 TABLETS PER 25 DAYS. PRESCRIBER MAY SUBMIT MAX UNITOVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5794	01/01/2014	PHYSICAL ASSESSMENT LIMITED TO ONE PER YEAR.
5795	01/01/1900	PHYSICAL ASSESSMENT LIMITED TO ONE PER STATE FISCAL YEAR
5796	01/01/2014	TRANSPORTATION LIMITED TO 52 PER STATE FISCAL YEAR.
5797	01/01/1900	DME IS LIMITED TO $13,885 PER STATE FISCAL YEAR
5798	01/01/2014	CAREGIVER SUPPORT IS LIMITED TO 416 UNITS PER STATE FISCAL YEAR.
5799	01/01/1900	ANNOVERA LIMITED TO 1 PERSCRIPTION PER 365 ROLLING DAYS. IF MORE IS NEEDED, PAIS REQUIRED.
5800	01/01/2014	LIFE SKILLS TRAINING LIMITED TO 832 UNITS PER STATE FISCAL YEAR.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5801	01/01/1900	PEER SUPPORT LIMITED TO 416 UNITS PER STATE FISCAL YEAR
5802	01/01/2014	TRANSITION CARE LIMITED TO 416 UNITS PER B2I ELIGIBILITY PERIOD.
5803	01/01/1900	SECURITY DEPOSIT LIMITED TO $1,500 PER STATE FISCAL YEAR
5804	01/01/2014	HOME MODIFICATIONS LIMITED TO $5,000 PER STATE FISCAL YEAR.
5805	01/01/1900	MOVING EXPENSES LIMITED TO $300 PER STATE FISCAL YEAR
5806	01/01/2014	ADAPTIVE EQUIPMENT LIMITED TO $5,000 PER STATE FISCAL YEAR.
5807	01/01/1900	HOUSEHOLD GOODS LIMITED TO $3,000 PER STATE FISCAL YEAR
5808	01/01/1900	BAQSIMI LIMITED TO 2 UNITS PER 22 DAYS. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDEBY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5809	01/01/1900	GVOKE OR ZEGALOGUE LIMITED TO 2 SYRINGES PER 22 DAYS. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5810	01/01/2014	GLUCAGON AGENTS LIMITED TO 2 KITS PER 22 DAYS. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5811	01/01/1900	SUBMITTED NUMBER OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG PER 365 DAYS. PRESCRIBER MAY SUBMIT A PA REQUEST IF GREATER QTY NEEDED
5812	01/01/2014	SUBMITTED NUMBER OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG PER CALENDAR YEAR. PRESCRIBER MAY SUBMIT A PA REQUEST IF GREATER QTY NEEDED.
5813	01/01/1900	SUBMITTED NUMBER OF RXS EXCEEDS THE ALLOWED QTY OF 2 RXS PER CALENDAR MONTH. PRESCRIBER MAY SUBMIT A PA REQUEST IF GREATER QTY NEEDED
5821	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO CLINICAL PA ONLY UNIT.
5822	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO PA UNIT.
5823	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5824	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5825	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5826	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5827	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5828	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5829	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5830	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5831	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5832	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5833	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5834	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5835	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5837	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5838	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5880	01/01/2014	ESPDT SCREENING LIMITED TO ONE.
5881	01/01/1900	ESPDT SCREENING LIMITED TO ONE
5882	01/01/2014	ESPDT SCREENING LIMITED TO ONE.
5883	01/01/1900	ESPDT SCREENING LIMITED TO ONE
5884	01/01/2014	ESPDT SCREENING LIMITED TO ONE.
5885	01/01/1900	ESPDT SCREENING LIMITED TO ONE
5886	01/01/2014	ESPDT SCREENING LIMITED TO ONE.
5887	01/01/1900	ESPDT SCREENING LIMITED TO ONE
5888	01/01/2014	ESPDT SCREENING LIMITED TO ONE.
5889	01/01/1900	ESPDT SCREENING LIMITED TO ONE
5890	01/01/2014	ESPDT SCREENING LIMITED TO ONE.
5891	01/01/1900	ESPDT SCREENING LIMITED TO ONE
5892	01/01/2014	ESPDT SCREENING LIMITED TO ONE.
5893	01/01/1900	ESPDT SCREENING LIMITED TO ONE
5894	01/01/2014	ESPDT SCREENING LIMITED TO ONE.
5895	01/01/1900	ESPDT SCREENING LIMITED TO ONE
5896	01/01/2014	ESPDT SCREENING LIMITED TO ONE.
5897	01/01/1900	ESPDT SCREENING LIMITED TO ONE
5900	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5901	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5902	01/01/2014	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5903	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5904	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5905	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5906	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5907	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5908	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5910	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5911	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5912	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5913	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5914	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED. HARM QL 100 PER 23 DAYS (BP100,200,400,700)
5915	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5916	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5917	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5918	01/01/2014	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5919	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5920	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5921	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5922	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5923	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5925	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5926	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5927	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5928	01/01/1900	PHARM QL 17 PER 23 DAYS (BP 100,200,400)
5930	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5931	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5940	01/01/2014	PREFERRED LABELER OF EPIPEN IS LIMITED TO 2 PENS IN 31 DAYS. EXCEEDS THE MONTHLY QUANTITY LIMIT. MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLYUNIT.
5941	01/01/1900	KETOROLAC TABLETS LIMITED TO 20 PER 23 DAYS.
5943	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5944	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5945	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5946	01/01/2014	PHARM QL Proair 2 PER 23 DAYS (BP 100,200,400)
5947	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5948	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5949	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5950	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5952	01/01/2014	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
5953	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5954	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5955	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5956	01/01/2014	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5957	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5958	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5959	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5960	01/01/2014	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5961	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5962	01/01/2014	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5963	01/01/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.

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EOB Code	Effective Date	Description
5964	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5965	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5966	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5967	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5968	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5969	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5970	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5971	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5972	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5973	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5974	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5975	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5976	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5977	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5982	01/01/2014	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.

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EOB Code	Effective Date	Description
5983	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
5984	01/01/2014	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5985	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5986	01/01/2014	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5987	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5988	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5989	01/01/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5990	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5991	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5992	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5993	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5994	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5995	01/01/1900	ER BENZOS HAVE A CUMULATIVE QUANTITY LIMIT OF 31 TABLETS/26 DAYS.
5996	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5997	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5998	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.

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EOB Code	Effective Date	Description
5999	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
6000	01/01/1900	PENDING MANUAL PRICING
6001	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
6002	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
6004	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
6005	01/01/1900	PHARM QL BENZO 31 PER 26 DAYS (BP 200,400)
6006	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
6007	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
6008	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
6009	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
6010	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
6011	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6012	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6013	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6014	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6015	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.

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EOB Code	Effective Date	Description
6017	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED
6018	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6019	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6020	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6021	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6022	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6023	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6024	01/01/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6025	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT OF 62 TABS IN 31 DAYS, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
6027	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6028	01/01/2014	EXCEEDS MONTHLY QUANTITY LIMIT, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
6029	01/01/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6030	01/01/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6031	01/01/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6032	01/01/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6033	01/01/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6034	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6035	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6036	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6037	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
6038	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
6039	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
6040	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
6041	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
6042	01/01/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
6043	01/01/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
6044	01/01/2014	PHARM QL Vaccines 0.5 PER 9999 DAYS (BP100,400)
6045	01/01/1900	THE QUANTITY ON THE HYSINGLA ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6046	01/01/1900	THE QUANTITY ON THE ZOHYDRO ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6047	01/01/1900	THE QUANTITY ON THE METHADONE CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6048	01/01/1900	THE QUANTITY ON THE MORPHINE ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6049	01/01/1900	THE QUANTITY ON THE XTAMPZA ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6050	01/01/1900	THE QUANTITY ON THE BUTRANS CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYSEXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6051	01/01/1900	THE QUANTITY ON THE BELBUCA CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYSEXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6052	01/01/1900	THE QUANTITY ON THE ARYMO ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6053	01/01/1900	THE QUANTITY ON THE MORPHABOND ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6055	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6056	01/01/1900	THE ADDITION OF A 4TH OR > CONCURRENT ORAL ANTIHYPERGLYCEMIC AGENT REQUIRES CLINICAL PA. THERE IS A HISTORY OF A 3-DRUG COMBINATION HYPOGLYCEMIC IN THE PAST 30 DAYS. REQUESTED SINGLE ENTITY HYPOGLYCEMIC RX IS THE 4TH ORAL HYPOGLYCEMIC
6057	01/01/1900	THE ADDITION OF A 4TH OR > CONCURRENT ORAL ANTIHYPERGLYCEMIC AGENT REQUIRES CLINICAL PA. THERE IS A HISTORY OF 2 OR MORE COMBINATION HYPOGLYCEMIC IN THE PAST30 DAYS. REQUESTED SINGLE ENTITY HYPOGLYCEMIC RX IS THE 4TH ORAL HYPOGLYCEMIC
6058	01/01/1900	THE ADDITION OF A 4TH OR > CONCURRENT ORAL ANTIHYPERGLYCEMIC AGENT REQUIRES CLINICAL PA. THERE IS A HISTORY OF 3 OR MORE ORAL HYPOGLYCEMICS IN THE PAST 30 DAYS. REQUESTED SINGLE ENTITY HYPOGLYCEMIC RX IS THE 4TH ORAL HYPOGLYCEMIC
6060	01/01/1900	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
6061	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6062	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
6063	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6064	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6065	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6066	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6067	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
6068	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6069	01/01/1900	EXCEEDS MONTHLY QUANTITY LIMIT, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
6071	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
6072	01/01/1900	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
6073	01/01/1900	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
6074	01/01/1900	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
6075	01/01/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6076	01/01/1900	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
6077	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6078	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
6079	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6080	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6081	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6082	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6083	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6084	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6085	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6086	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6087	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6088	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6089	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6090	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6091	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6092	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6095	01/01/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6100	01/01/1900	SIMVASTATIN 80 MG IS LIMITED TO 1 PER DAY. IF MORE IS NEEDED, CLINICAL PA IS REQUIRED.
6101	01/01/1900	SIMVASTATIN 40 MG IS LIMITED TO 2 PER DAY. IF MORE IS NEEDED, CLINICAL PA IS REQUIRED.
6102	01/01/1900	SIMVASTATIN 20 MG IS LIMITED TO 4 PER DAY. IF MORE IS NEEDED, CLINICAL PA IS REQUIRED.
6103	01/01/1900	SIMVASTATIN 10 MG IS LIMITED TO 8 PER DAY. IF MORE IS NEEDED, CLINICAL PA IS REQUIRED.
6392	01/01/2014	THIS SERVICE IS NOT PAYABLE WITH ANOTHER SERVICE ON THE SAME DATE OF SERVICE DUE TO NATIONAL CORRECT CODING INITIATIVE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6393	01/01/1900	A PREVIOUSLY PAID SERVICE IS BEING RECOUPED PER NATIONAL CORRECT CODING INITIATIVE (NCCI) PROCESSING OF ANOTHER SERVICE ON THE SAME DATE OF SERVICE BY THE SAME PROVIDER.
6394	01/01/1900	THIS SERVICE IS NOT PAYABLE WITH ANOTHER SERVICE ON THE SAME DATE OF SERVICE DUE TO NATIONAL CORRECT CODING INITIATIVE.
6395	01/01/1900	A PREVIOUSLY PAID SERVICE IS BEING RECOUPED PER NATIONAL CORRECT CODING INITIATIVE (NCCI) PROCESSING OF ANOTHER SERVICE ON THE SAME DATE OF SERVICE BY THE SAME PROVIDER.
6400	01/01/2014	MILEAGE PROCEDURE CODE BILLED WITHOUT A BASE RATE CODE.
6401	01/01/1900	VACCINE ADMINISTRATION CODE NOT PAYABLE WITHOUT VFC VACCINE PAID ON SAME DATE OF SERVICE
6402	01/01/2014	Not Used
6403	01/01/1900	VACCINE ADMINISTRATION MUST BE BILLED WITH A VACCINE CODE FOR THE SAME DATE OFSERVICE BY THE SAME PROVIDER
6404	01/01/2014	IMMUNIZATION ADMINISTRATION MUST BE BILLED WITH THE IMMUNIZATION VACCINE OR TOXOID FOR THE SAME DATE OF SERVICE.
6405	01/01/1900	INCOMING LONG ACTING OPIOID IS THE 1ST OPIOID RX FILLED IN THE PAST 90 DAYS. NEW OPIOID PRESCRIPTIONS MUST BE FOR AN IMMEDIATE RELEASE OR SHORT ACTING PRODUCT. PHARMACY CLAIMS INDICATE NO PREVIOUS IR/SA OPIOID FILLED IN THE PAST 90 DAYS.
6406	01/01/2014	SURGICAL TRAY MUST BE BILLED WITH APPROVED SURGICAL CODE.
6408	01/01/2014	CRITICAL CARE ADD ON MUST BE BILLED WITH CRITICAL CARE PRIMARY PROCEDURE FOR THE SAME DATE OF SERVICE BY THE SAME PROVIDER.
6409	01/01/1900	TINT PROCEDURES CANNOT BE BILLED WITHOUT A PAID LENS PROCEDURE
6410	01/01/2014	REUSE
6411	01/01/1900	SURGICAL SERVICES AND ROUTINE PREOPERATIVE MEDICAL VISITS ARE NOT SEPARATELY PAYABLE. A PREVIOUSLY PAID ROUTINE PREOPERATIVE MEDICAL VISIT IS BEING RECOUPED
6415	01/01/1900	Multiple Surgeries Not Allowed Same DOS Same Claim
6420	01/01/2014	ASSISTANT SURGEON/SURGEON MUST FILE SEPARATELY
6421	01/01/1900	IMPROPER USE OF ASSISTANT SURGEON MODIFIERS
6422	01/01/2014	A HISTORY OF 1 CLAIM WITH AN OPIOID IN THE PAST 30 DAYS IS REQUIRED FOR APPROVAL OF AMITIZA 24 MCG, MOVANTIK, RELISTOR OR SYMPROIC. NO OPIOID RX FOUND IN THEPAST 30 DAYS.
6425	01/01/1900	FAMILY PLANNING SERVICE BILLED AFTER STERILIZATION OR HYSTERECTOMY SERVICE
6426	01/01/2014	THE STERILIZATION/HYSTERECTOMY SERVICE IS BEING PAID AND A FAMILY PLANNING SERVICE WITH A DATE OF SERVICE AFTER THE STERILIZATION/HYSTERECTOMY IS BEING RECOUPED.
6430	01/01/2014	PATIENT HAS A HISTORY OF ATRIAL FIBRILLATION, OR HISTORY OF A HIP OR KNEE REPLACEMENT IN THE PAST 30 DAYS. USE OF ELIQUIS STARTER PACK IS CONTRAINDICATED WITHTHIS DIAGNOSIS.
6431	01/01/1900	TBD
6432	01/01/1900	90472 must be billed with 2 Vaccines - same claim

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6435	01/01/1900	CONCOMITANT USE OF A GLP-1 AND A DPP-4 HYPOGLYCEMIC AGENT REQUIRES A CLINICAL PA FOR APPROVAL
6437	01/01/1900	EMR visits must include ET modifier on 2nd day services. A claim in history foran EMR visit is paid for overlapping dates of services.
6445	01/01/1900	INCOMING LONG ACTING OPIOID IS THE 1ST OPIOID RX FILLED IN THE PAST 90 DAYS. NEW OPIOID PRESCRIPTIONS MUST BE FOR AN IMMEDIATE RELEASE OR SHORT ACTING PRODUCT. PHARMACY CLAIMS INDICATE NO PREVIOUS IR/SA OPIOID FILLED IN THE PAST 90 DAYS
6450	01/01/1900	DELIVERY SERVICES LIMITED TO ONCE PER 8 MONTHS
6460	01/01/1900	DRUG MUST HAVE OPIOID PRESCRIPTION IN PAST 30 DAYS.
6461	01/01/1900	SA & LA NARCOTIC NOT ALLOWED WITH SUBOXONE IN THE PAST 30 DAYS. REQUIRES A CLINICAL PA FOR APPROVAL.
6502	01/01/1900	ROUTINE POST-OPERATIVE MEDICAL VISITS ARE NOT SEPARATELY PAYABLE. THE SURGICALSERVICE WILL BE SET TO PAY AND THE E&M SERVICE WILL BE DENIED.
6503	01/01/1900	MULTIPLE TRIVALENT VACCINES NOT PAYABLE ON THE SAME DATE OF SERVICE BY THE SAMEPROVIDER
6505	01/01/1900	90460 AND 90471-90474 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE BY THE SAME RENDERING PROVIDER
6506	01/01/2014	PATIENT HAS A HISTORY OF ATRIAL FIBRILLATION, OR HISTORY OF A HIP OR KNEE REPLACEMENT IN THE PAST 30 DAYS. USE OF ELIQUIS STARTER PACK IS CONTRAINDICATED WITHTHIS DIAGNOSIS.
6507	01/01/1900	PREVENTATIVE MEDICINE COUNSELING/RISK FACTOR REDUCTION CODES AND PREVENTATIVE MEDICINE CODES ARE NOT PAYABLE ON THE SAME DATE OF SERVICE BY THE SAME RENDERINGPROVIDER
6510	01/01/1900	PRADAXA 110 MG IS NOT INDICATED FOR KNEE REPLACEMENT SURGERY.
6511	01/01/1900	DENTAL SERVICES CANNOT BE BILLED FOR A PREVIOUSLY EXTRACTED TOOTH
6512	01/01/2014	DENTAL EXTRACTION HAS ALREADY BEEN PAID FOR THE SAME TOOTH.
6513	01/01/1900	ALVEOLECTOMY SURGICAL EXTRACTION LIMITED TO 1 PER AREA OF ORAL CAVITY PER DATEOF SERVICE
6515	01/01/1900	ROOT TIP REMOVAL NOT ALLOWED ON SAME DATE OF SERVICE, SAME TOOTH, AS EXTRACTION.
6516	01/01/1900	ROOM AND BOARD AND THERAPEUTIC LEAVE ARE NOT PAYABLE FOR SAME OR OVERLAPPING DATES OF SERVICE.
6518	01/01/2014	DME REPLACEMENT/REPAIR BILLED BEFORE PURCHASE
6519	01/01/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE
6521	01/01/1900	LENSES LIMITED TO ONE PAIR PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY
6525	01/01/1900	PHARMACY CLAIMS INDICATE REQUESTED OPIOID PRESCRIPTION IS THE 1ST OPIOID RX FILLED IN THE PAST 90 DAYS. NEW SHORT ACTING OPIOID PRESCRIPTIONS ARE LIMITED TO AMAXIMUM 7-DAY SUPPLY. REQUESTED SHORT ACTING OPIOID RX FOR > 7-DAY SUPPLY EXCEEDS THIS LIMIT.
6526	01/01/2014	TBD
6527	01/01/1900	TBD
6528	01/01/2014	TBD

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6529	01/01/1900	TBD
6530	01/01/2014	EYE GLASSES FITTING LIMITED TO ONCE PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY.
6531	01/01/1900	FRAMES LIMITED TO ONCE PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY.
6535	01/01/1900	OUTPATIENT HOSPITAL SERVICE NOT ALLOWED WITH ANOTHER PAID OUTPATIENT HOSPITAL SERVICE WITH OVERLAPPING DATES OF SERVICE BY THE SAME PROVIDER.
6536	01/01/1900	G0378 MUST BE BILLED ONLY ONCE PER CLAIM.
6537	01/01/1900	EMR visits must include ET modifier on 2nd day services. A claim in history foran EMR visit is paid for overlapping dates of services.
6540	01/01/2014	SAME SEDATIVE HYPNOTIC PAID WITHIN THE PAST 25 DAYS.
6545	01/01/1900	MULTIPLE DELIVERY OR BIRTH SERVICES MUST BE BILLED ON THE SAME CLAIM. A PAID CLAIM WITH A MULTIPLE DELIVERY OR BIRTH SERVICE WAS FOUND FOR THE SAME DATE OF SERVICE.
6565	01/01/1900	MULTIPLE VACCINES FOR THE SAME DOS MUST BE BILLED ON THE SAME CLAIM.
6590	01/01/2014	ADD-ON CODES ARE PERFORMED IN ADDITION TO THE PRIMARY SERVICE OR PROCEDURE ANDCANNOT BE REPORTED AS A STAND-ALONE SERVICE.
6600	01/01/1900	PHARMACY HISTORY INDICATES PATIENT IS CURRENTLY ON A BENZODIAZEPINE. CONCOMITANT USE OF A LONG ACTING OPIOID AND A BENZODIAZEPINE IS CONTRAINDICATED AND REQUIRES A MANUAL PA FOR APPROVAL.
6601	01/01/1900	PHARMACY HISTORY INDICATES PATIENT IS CURRENTLY ON AN OPIOID. CONCOMITANT USE OF A BENZODIAZEPINE AND AN OPIOID IS CONTRAINDICATED AND REQUIRES A CLINICAL PAFOR APPROVAL.
6637	01/01/1900	EMR visits must include ET modifier on 2nd day services. A claim in history foran EMR visit is paid for overlapping dates of services.
7001	01/01/1900	CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT
7002	01/01/1900	MINIMUM DURATION OF THERAPY PROSPECTIVE DUR ALERT.
7003	01/01/1900	DRUG-DRUG INTERACTION PROSPECTIVE DUR ALERT
7004	01/01/1900	DD PROSPECTIVE DUR ALERT; EOB NOT USED
7005	01/01/1900	DRUG-DISEASE (REPORTED) PROSPECTIVE DUR ALERT
7006	01/01/1900	MC PROSPECTIVE DUR ALERT; EOB NOT USED
7007	01/01/1900	DRUG-DISEASE (INFERRED) PROSPECTIVE DUR ALERT
7008	01/01/1900	DC PROSPECTIVE DUR ALERT; EOB NOT USED
7009	01/01/1900	THERAPEUTIC DUPLICATION PROSPECTIVE DUR ALERT
7010	01/01/1900	DRUG-PREGNANCY PROSPECTIVE DUR ALERT
7011	01/01/1900	EARLY REFILL PROSPECTIVE DUR ALERT
7012	01/01/1900	ADDITIVE TOXICITY PROSPECTIVE DUR ALERT
7013	01/01/1900	DRUG-AGE PROSPECTIVE DUR ALERT
7014	01/01/1900	INGREDIENT DUPLICATION PROSPECTIVE DUR ALERT.
7015	01/01/1900	LATE REFILL PROSPECTIVE DUR ALERT
7016	01/01/1900	HIGH DOSE PROSPECTIVE DUR ALERT
7017	01/01/1900	MAXIMUM DURATION OR THERAPY PROSPECTIVE DUR ALERT.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
7018	01/01/1900	LOW DOSE PROSPECTIVE DUR ALERT.
7019	01/01/1900	EARLY REFILL ALERT. POLICY OVERRIDE MUST BE GRANTED BY THE DRUG AUTHORIZATIONAND POLICY OVERRIDE CENTER TO DISPENSE EARLY.
7020	01/01/1900	RESERVED FOR FUTURE USE.
7021	01/01/1900	RESERVED FOR FUTURE USE.
7022	01/01/1900	RESERVED FOR FUTURE USE.
7200	01/01/1900	SERVICE ROUTINELY COVERED ONCE PER SIX MONTHS. PAYMENT HAS ALREADY BEEN MADE. FOR REVIEW OF MEDICAL NECESSITY, RESUBMIT WITH FULL DOCUMENTATION.
7201	01/01/1900	YOU ARE BILLLING MORE THAN 23 NH THERAPIES IN ONE CALENDAR MONTH. CONTACT THE LONG TERM CARE COORDINATOR FOR REVIEW. IF SERVICES ARE AUTHORIZED, RESUBMIT WITHTHE APPROVAL LETTER.
7211	01/01/1900	PROCEDURE IS INVALID FOR PATIENT'S AGE
7212	01/01/1900	PROCEDURE ADDED DUE TO ALT CODE REPLACEMENT (AGE)
7213	01/01/1900	PROCEDURE IS INVALID FOR PATIENT'S SEX
7214	01/01/1900	PROCEDURE ADDED DUE TO ALT CODE REPLACEMENT (SEX)
7215	01/01/1900	PROCEDURE CODE IS INCIDENTAL
7217	01/01/1900	PROCEDURE CODE HAS BEEN REBUNDLED
7218	01/01/1900	PROCEDURE ADDED DUE TO REBUNDLING
7219	01/01/1900	PROCEDURE IS MUTUALLY EXCLUSIVE
7233	01/01/1900	DENIED DUPLICATE- INCLUDES UNILATERAL OR BILAT
7234	01/01/1900	DENIED DUPLICATE - IS BILATERAL
7235	01/01/1900	DENIED DUPLICATE - ONLY DONE XX TIMES IN LIFETIME
7236	01/01/1900	DENIED DUPLICATE - ONLY DONE XX TIMES IN A DAY
7237	01/01/1900	DENIED DUPLICATE (REBUNDLED)
7238	01/01/1900	PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING
7239	01/01/1900	PROCEDURE IS A POSSIBLE DUPLICATE
7256	01/01/1900	MODIFIER INVALID FOR PROCEDURE CODE BILLED.
7257	01/01/1900	INCIDENTAL MODIFIER IS REQUIRED FOR SECONDARY PROCEDURE CODE.
7258	01/01/1900	REVIEW MODIFIER 51
7259	01/01/1900	SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS.
7290	01/01/1900	INVALID MODIFIER REMOVED FROM PRIMARY PROCEDURE CODE BILLED.
7291	01/01/1900	INCIDENTAL MODIFIER WAS ADDED TO THE SECONDARY PROCEDURE CODE.
7500	01/01/1900	BILLING PROVIDER ON PREPAYMENT REVIEW
7503	01/01/1900	REASON FOR SERVICE SUBMITTED DOES NOT MATCH PROSPECTIVE DUR DENIAL ON ORIGINALCLAIM.
7504	01/01/1900	DENIED. PROFESSIONAL SERVICE CODE IS INVALID.
7505	01/01/1900	DENIED. RESULT OF SERVICE CODE IS INVALID.
7506	01/01/1900	DENIED. PROSPECTIVE DUR DENIAL ON ORIGINAL CLAIM CAN NOT BE OVERRIDDEN.
7507	01/01/1900	DENIED. RESULT OF SERVICE SUBMITTED INDICATES THE PRESCRIPTION WAS "NOT FILLED".

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
7508	01/01/1900	DENIED. RESULT OF SERVICE SUBMITTED INDICATES THE PRESCRIPTION WAS FILLED WITHA DIFFERENT QUANTITY. QUANTITY SUBMITTED MATCHES ORIGINAL CLAIM.
8000	01/01/1900	RESOLUTION REVIEW.
8001	01/01/1900	NOT USED - DMAP WAS UNABLE TO PROCESS THIS REQUEST DUE TO ILLEGIBLE INFORMATION.
8002	01/01/1900	UNABLE TO PROCESS THIS REQUEST DUE TO EITHER MISSING, INVALID OR MISMATCHED NATIONAL PROVIDER IDENTIFIER # (NPI)/PROVIDER NAME/POP ID.
8003	01/01/1900	THE NUMBER IN THE NATIONAL PROVIDER IDENTIFIER (NPI) SECTION ON THIS REQUEST ISNOT A NUMBER ASSIGNED TO A FORWARDHEALTH CERTIFIED NURSING FACILITY FOR THIS DATE OF SERVICE.
8004	01/01/1900	NOT USED - DMAP WAS UNABLE TO PROCESS THIS REQUEST. THE RESIDENT OR CNA'S NAMEI S MISSING.
8005	01/01/1900	NOT USED - DMAP WAS UNABLE TO PROCESS THIS REQUEST. ALL REQUESTS MUST HAVE A 9D IGIT SOCIAL SECURITY NUMBER.
8006	01/01/1900	NOT USED - DMAP IS UNABLE TO PROCESS THIS REQUEST BECAUSE THE SIGNATURE/DATE FIEL D IS BLANK
8007	01/01/1900	THE SCREEN DATE IS EITHER MISSING OR INVALID. THE SCREEN DATE MUST BE IN MM/DD/CCYY FORMAT.
8008	01/01/1900	OBRA-NURSE AND/OR LEVEL 1.
8009	01/01/1900	INVALID ADMISSION DATE. EITHER THE DATE WAS NOT IN MM/DD/CCYY FORMAT OR IT'S AFUTURE DATE.
8010	01/01/1900	THIS IS NOT A REIMBURSABLE LEVEL I SCREEN. DID YOU CHECK MORE THAN ONE BOX? IFSO, CORRECT AND RESUBMIT.
8011	01/01/1900	REQUEST DENIED BECAUSE THE SCREEN DATE IS AFTER THE ADMISSION DATE. THIS IS NOT A PREADMISSION SCREEN AND IS NOT REIMBURSABLE.
8012	01/01/1900	REQUEST DENIED DUE TO LATE BILLING. A REIMBURSEMENT REQUEST FOR A LEVEL I SCREEN MUST BE RECEIVED AT FORWARDHEALTH WITHIN A YEAR OF THE SCREEN DATE.
8013	01/01/1900	REQUEST DENIED BECAUSE THE SCREEN WAS DONE MORE THAN 90 DAYS PRIOR TO THE ADMISSION DATE.
8014	01/01/1900	THIS CNA'S SOCIAL SECURITY NUMBER, SSN, IS NOT ON THE HP NURSE AIDE REGISTRY FLE. THIS INDIVIDUAL IS EITHER NOT ON THE REGISTRY OR THE SSN ON THE REQUEST DOESN'T MATCH THE SSN THAT'S BEEN INPUTTED ON THE REGISTRY.
8015	01/01/1900	THE REIMBURSEMENT CODE ASSIGNED TO THIS CERTIFICATION SEGMENT DOES NOT AUTHORIZE A NAT PAYMENT.
8016	01/01/1900	THE REIMBURSEMENT CODE ASSIGNED TO THIS CERTIFICATION SEGMENT DOES NOT AUTHORIZE A TRAINING PAYMENT. THE CNA IS ONLY ELIGIBLE FOR TESTING REIMBURSEMENT.
8017	01/01/1900	UNABLE TO PROCESS THIS REQUEST BECAUSE THE "COMPETENCY TEST DATE" AND "TRAININGCOMPLETION DATE" FIELDS ARE BLANK.
8018	01/01/1900	COMPETENCY TEST DATE IS NOT A VALID DATE. IT MUST BE IN MM/DD/YY FORMAT ANDCAN NOT BE A FUTURE DATE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
8019	01/01/1900	TRAINING COMPLETION DATE IS NOT A VALID DATE. IT MUST BE IN MM/DD/YY FORMATAND CAN NOT BE A FUTURE DATE.
8020	01/01/1900	THE "COMPETENCY TEST DATE" ON THE REQUEST DOES NOT MATCH THE CNA'S TEST DATE ONTHE WI NURSE AIDE REGISTRY. FOR NEWLY CERTIFIED CNAS, "DATE OF INCLUSION" IS THE TEST DATE.
8021	01/01/1900	NOT USED - WI DMAP CAN NOT ISSUE A NAT PAYMENT WITHOUT A VALID HIRE DATE.
8022	01/01/1900	CNAS ELIGIBILITY FOR NAT REIMBURSEMENT HAS EXPIRED. THE TIMEFRAME BETWEEN CERTIFICATION, TEST, DATE AND HIRE DATE EXCEEDS A YEAR.
8023	01/01/1900	NF'S ELIGIBILITY FOR REIMBURSEMENT HAS EXPIRED. A NAT REIMBURSEMENT REQUEST MUST BE SUBMITTED TO WI FORWARDHEALTH WITHIN A YEAR OF THE CNA'S HIRE DATE.
8024	01/01/1900	NF'S ELIGIBILITY FOR REIMBURSEMENT HAS EXPIRED. IF A CNA OBTAINS HIS/HER CERTIFICATION AFTER THEY'VE BEEN HIRED BY A NF, A NF HAS A YEAR FROM THEIR CERTIFICATION, TEST, DATE TO SUBMIT A REIMBURSEMENT REQUEST TO FORWARDHEALTH.
8025	01/01/1900	REQUEST FOR TRAINING REIMBURSEMENT DENIED. TIMEFRAME BETWEEN THE CNA'S TRAINING DATE AND TEST DATE EXCEEDS 365 DAYS. "TRAINING COMPLETION DATE" MUST BE WITHIN A YEAR OF THE CNA'S CERTIFICATION, TEST, DATE.
8026	01/01/1900	NF'S ELIGIBILITY FOR REIMBURSEMENT HAS EXPIRED. REQUESTS FOR TRAINING REIMBURSEMENT DENIED DUE TO LATE BILLING.
8027	01/01/1900	TRAINING REQUEST DENIED BECAUSE EITHER THE TRAINING DATE ON THE REQUEST IS AFTER THE CNA'S CERTIFICATION TEST DATE OR IT'S NOT WITHIN A YEAR OF THAT DATE.
8028	01/01/1900	CNAS ELIGIBILITY FOR TRAINING REIMBURSEMENT HAS EXPIRED. "TRAINING COMPLETIONDATE" EXCEEDS THE CURRENT ELIGIBILITY TIMELINE.
8029	01/01/1900	NF'S ELIGIBILITY FOR REIMBURSEMENT HAS EXPIRED. TRAINING REIMBURSEMENT DENIEDDUE TO "LATE BILLING". REQUEST WAS NOT SUBMITTED WITHIN A YEAR OF THE CNA'S HIRE DATE.
8030	01/01/1900	THE REIMBURSEMENT CODE ASSIGNED TO THIS CNA DOES NOT AUTHORIZE A NAT PAYMENT.
8032	01/01/1900	NOT USED - THIS IS A DUPLICATE REQUEST. DMAP HAS ALREADY ISSUED A PAYMENT TO YOU R NF FOR THIS LEVEL L SCREEN. CHECK YOUR CURRENT/PREVIOUS PAYMENT REPORTS FOR PAYMENT
8033	01/01/1900	NOT USED - THIS IS A DUPLICATE REQUEST. DMAP HAS ALREADY ISSUED A PAYMENT TO YOU R NF FOR A LEVEL I SCREEN WITH THE SAME ADMISSION DATE.
8034	01/01/1900	MULTIPLE REQUESTS RECEIVED FOR THIS SSN WITH THE SAME SCREEN DATE. A PAYMENT HAS ALREADY BEEN ISSUED TO A DIFFERENT NF.
8035	01/01/1900	MULTIPLE SCREENS PERFORMED WITHIN A FIFTEEN DAY TIME FRAME FOR THIS SSN. FORWARDHEALTH WILL ONLY PAY FOR ONE. A PAYMENT HAS ALREADY BEEN ISSUED FOR THIS SSN
8036	01/01/1900	A TRAINING PAYMENT HAS ALREADY BEEN ISSUED TO A DIFFERENT NF FOR THIS CNA.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
8037	01/01/1900	A TRAINING PAYMENT HAS ALREADY BEEN ISSUED TO YOUR NF FOR THIS CNA.
8038	01/01/1900	REIMBURSEMENT FOR TRAINING IS ONE TIME ONLY. A TRAINING PAYMENT HAS ALREADY BEEN ISSUED FOR THIS CNA.
8039	01/01/1900	A PAYMENT FOR THE CNA'S COMPETENCY TEST HAS ALREADY BEEN ISSUED.
8040	01/01/1900	THE "TRAINING COMPLETION DATE" ON THIS REQUEST IS AFTER THE CNA'S CERTIFICATIONTEST DATE. "TRAINING COMPLETION DATE" MUST BE PRIOR TO AND WITHIN A YEAR OF THE CNA'S CERTIFICATION DATE.
8041	01/01/1900	REIMBURSEMENT FOR THIS CERTIFICATION, TEST, SEGMENT HAS BEEN ISSUED TO ANOTHERNF.
8042	01/01/1900	REIMBURSEMENT FOR THIS CERTIFICATION, TEST, SEGMENT HAS ALREADY BEEN ISSUED TOYOUR NF.
8183	01/01/1900	PATIENT LIABILITY ADJUSTMENTS
8186	01/01/1900	MASS ADJUSTMENT - PROVIDER RATE PROCESS.
8188	01/01/1900	MASS ADJUSTMENT - VOID TRANSACTIONS
8192	01/01/1900	THIS CLAIM HAS BEEN ADJUSTED DUE TO MEDICARE PART D COVERAGE.
8193	01/01/1900	THIS CLAIM HAS BEEN ADJUSTED DUE TO A CHANGE IN THE MEMBER'S ENROLLMENT.
8194	01/01/1900	THIS CLAIM HAS BEEN ADJUSTED BECAUSE A SERVICE ON THIS CLAIM IS NOT PAYABLE INCONJUNCTION WITH A SEPARATE PAID SERVICE ON THE SAME DATE OF SERVICE DUE TO NATIONAL CORRECT CODING INITIATIVE.
8195	01/01/1900	PROVIDER REQUEST CASH ADJUSTMENT
8196	01/01/1900	PROVIDER REQUEST CASH VOID
8197	01/01/1900	PROVIDER REQUEST TPL CASH ADJUSTMENT
8198	01/01/1900	PROVIDER REQUEST TPL CASH VOID
8200	05/01/1994	TPL PRIVATE HEALTH INSURANCE - CARRIER
8201	05/01/1994	TPL PRIVATE HEALTH INSURANCE - PROVIDER
8202	05/01/1994	TPL PRIVATE HEALTH INSURANCE - MEMBER
8203	05/01/1994	AUTO LIABILITY - CARRIER
8204	01/01/1990	AUTO LIABILITY - PROVIDER
8205	01/01/1994	AUTO LIABILITY - MEMBER
8206	01/01/1990	NON-AUTO LIABILITY - CARRIER
8207	01/01/1990	NON-AUTO LIABILITY - PROVIDER
8208	01/01/1994	NON-AUTO LIABILITY - MEMBER
8209	01/01/1990	WORKER'S COMP - CARRIER
8210	01/01/1990	WORKER'S COMP - PROVIDER
8211	01/01/1994	WORKER'S COMP - MEMBER
8212	01/01/1990	PROBATE'S ESTATE
8213	01/01/1990	INCOME PENSION TRUST RECOVERIES
8214	01/01/1990	VICTIM'S RESTITUTION
8215	01/01/1994	ABSENT PARENTS
8216	01/01/1994	TPL ERROR
8217	01/01/1994	DUE TO MISCELLANEOUS OR UNSPECIFIED REASON
8220	01/01/1900	RESERVED FOR FUTURE USE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
8221	01/01/1900	RESERVED FOR FUTURE USE.
8222	01/01/1900	ADJUSTMENT/RESUBMISSION WAS INITIATED BY PROVIDER
8223	01/01/1900	RESERVED FOR FUTURE USE.
8224	01/01/1900	RESERVED FOR FUTURE USE.
8225	05/01/1994	CAPITATION - DEATH OF MEMBER
8226	01/01/1999	CAPITATION - MEMBER INCARCERATED
8227	01/01/1990	CAPITATION - EPSDT CLAIM
8228	01/01/1990	CAPITATION - MEMBER ENROLLED IN ERROR
8229	05/01/1994	CAPITATION - FAMILY PLANNING
8230	05/01/1994	CAPITATION - INCORRECT RATE CATEGO
8231	05/01/1994	CAPITATION - DEMOGRAPHIC CHANGE
8232	05/01/1994	CAPITATION - OTHER
8233	01/01/1900	ADJUSTMENT/RESUBMISSION WAS INITIATED BY DOM
8234	01/01/1900	NOT USED- DMAP-INITIATED CLAIM ADJUSTMENT. SEE TOPIC #13437 IN THE ONLINE HANDBO OK FOR COMPLETE INFORMATION ON THIS TYPE OF CLAIM ADJUSTMENT.
8240	01/01/1994	ADJUSTMENT GENERATED DUE TO SUR REVIEW
8241	01/01/1994	ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY
8242	01/01/1994	ADJUSTMENT GENERATED DUE TO RATE CHANGE
8244	01/01/1994	PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE
8245	01/01/1900	POINT OF SALE
8246	01/01/1900	POINT OF SALE REVERSAL
8299	01/01/1990	ADJUSTMENT TO CROSSOVER PAID PRIOR TO AIM IMPLEMENTATION DATE. THIS CLAIM HASBEEN MANUALLY PRICED USING THE MEDICARE COINSURANCE, DEDUCTIBLE, AND PSYCHE REDUCTION AMOUNTS AS BASIS FOR REIMBURSEMENT.
8410	01/01/1900	FINANCIAL CHECK VOID/STOP PAY
8515	01/01/1900	THIS CLAIM HAS BEEN DENIED DUE TO A POS REVERSAL TRANSACTION.
8901	01/01/1900	OTHER COMMERCIAL INSURANCE RESPONSE NOT RECEIVED WITHIN 90 DAYS FOR PROVIDER BASED BILL.
8902	01/01/1900	OTHER MEDICARE PART A RESPONSE NOT RECEIVED WITHIN 90 DAYS FOR PROVIDER BASED BILL.
8903	01/01/1900	OTHER MEDICARE PART B RESPONSE NOT RECEIVED WITHIN 90 DAYS FOR PROVIDER BASED BILL.
8904	01/01/1900	OTHER MEDICARE MANAGED CARE RESPONSE NOT RECEIVED WITHIN 120 DAYS FOR PROVIDERBASED BILL.
8999	01/01/1900	SUPERSUSPENDED FOR MISSING DISPOSITION
9000	01/01/1900	PRICING ADJUSTMENT - THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE. CLAIM PAID AT THE PROGRAM ALLOWED AMOUNT.
9001	01/01/1900	PRICING ADJUSTMENT - REIMBURSEMENT REDUCED BY THE MEMBER'S COPAYMENT AMOUNT.
9002	01/01/2000	PRICING ADJUSTMENT - PAYMENT AMOUNT INCREASED BASED ON AMBULATORY SURGERY CENTERS ACCESS PAYMENT POLICIES.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
9003	01/01/1900	PRICING ADJUSTMENT - THIRD PARTY LIABILITY AMOUNT APPLIED IS GREATER THAN THE AMOUNT PAID BY THE PROGRAM.
9004	01/01/1900	PRICING ADJUSTMENT - AMOUNT PAID IS ZERO.
9005	01/01/1900	THIS CLAIM IS ELIGIBLE FOR ELECTRONIC SUBMISSION. UP TO A $1.10 REDUCTION HAS BEEN APPLIED TO THIS CLAIM PAYMENT.
9006	01/01/1900	ACCESS PAYMENT INCLUDED.
9007	01/01/1900	ACCESS PAYMENT NOT AVAILABLE FOR DATE OF SERVICE ON THIS DATE OF PROCESS.
9008	01/01/1900	PRICING ADJUSTMENT - PAYMENT AMOUNT DECREASED BASED ON PAY FOR PERFORMANCE POLICY.
9013	01/01/1900	PHARMACEUTICAL CARE DENIED. TRADITIONAL DISPENSING FEE MAY BE ALLOWED.
9020	01/01/1900	SERVICE PAID IN ACCORDANCE WITH PROGRAM REQUIREMENTS.
9700	01/01/1900	TPL VENDOR INITIATED - VOID REVERSAL RESUBMISSION
9800	01/01/1900	PRICING ADJUSTMENT- ENCOUNTER CLAIM ZERO PAID.
9801	01/01/1900	CLAIM PAID AT PER DIEM RATE
9802	01/01/1900	CLAIM PAID AT % OF BILLED CHARGES
9803	01/01/1900	PRICING ADJUSTMENT - MEDICARE BENEFITS ARE EXHAUSTED. CLAIM PAID AT PROGRAM ALLOWED RATE.
9804	01/01/1900	DISPENSING FEE DENIED. MISSING OR INVALID LEVEL OF EFFORT SUBMITTED AND/OR REASON FOR SERVICE, PROFESSIONAL SERVICE, OR RESULT OF SERVICE CODE BILLED IN ERROR.
9805	01/01/1900	PRICING ADJUSTMENT - PAYMENT REDUCED DUE TO THE INPATIENT OR OUTPATIENT DEDUCTIBLE.
9806	01/01/1900	PRICING ADJUSTMENT - PAYMENT REDUCED DUE TO BENEFIT PLAN LIMITATIONS.
9807	01/01/1900	HEADER BILLING PROVIDER USED AS DETAIL PERFORMING PROVIDER
9808	01/01/1900	HEADER PERFORMING PROVIDER USED AS DETAIL PERFORMING PROVIDER
9809	01/01/1900	PRICING ADJUSTMENT - MAXIMUM ALLOWABLE FEE PRICING USED.
9810	01/01/1900	REPACKAGING ALLOWANCE APPLIED
9811	01/01/1900	PHARMACEUTICAL CARE RATE APPLIED.
9812	01/01/1900	LEVEL OF EFFORT DISPENSING FEE APPLIED.
9813	01/01/1900	TRADITIONAL DISPENSING FEE APPLIED.
9814	01/01/1900	DIAGNOSIS REQUIRED FOR PHARMACEUTICAL CARE. TRADITIONAL DISPENSING FEE MAY BE ALLOWED.
9815	01/01/1900	REFER TO THE DME AREA OF THE ONLINE HANDBOOK FOR CLAIMS SUBMISSION REQUIREMENTSFOR COMPRESSION GARMENTS. THE TOPIC OF REQUIREMENTS FOR COMPRESSION GARMENTS CAN BE FOUND IN THE CLAIMS SECTION, SUBMISSION CHAPTER.
9816	01/01/1900	PRICING ADJUSTMENT - PAYMENT AMOUNT INCREASED BASED ON HOSPITAL ACCESS PAYMENTPOLICIES.
9817	09/14/2009	BILLING PROVIDER NUMBER WAS USED TO ADJUDICATE THE SERVICE(S)
9818	01/01/1900	REPACKAGING ALLOWANCE IS NOT ALLOWED FOR UNIT DOSE NDCS.
9819	01/01/1900	EAPG PRICING APPLIED.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
9820	01/01/1900	DRG INTERIM PER DIEM PRICING APPLIED
9821	01/01/1900	DRG POLICY ADJUSTOR APPLIED
9822	01/01/1900	DRG TRANSFER PRICING APPLIED
9823	01/01/1900	DRG DAY OUTLIER APPLIED
9824	01/01/1900	DRG COST OUTLIER APPLIED
9825	01/01/1900	DRG PRORATE PRICING APPLIED
9850	01/01/1900	Copay Bypass - Copay N/A
9851	01/01/1900	Copay Bypass - Child
9852	01/01/1900	Copay Bypass - Tribal/American Indian
9853	01/01/1900	Copay Bypass - Provider Exempt
9854	01/01/1900	Copay Bypass - Family Planning
9855	01/01/1900	Copay Bypass - Pregnancy
9856	01/01/1900	Copay Bypass - COVID
9857	01/01/1900	Copay Bypass - HCBS
9858	01/01/1900	Copay Bypass - NH Resident
9859	01/01/1900	Copay Bypass - Mental Health
9860	01/01/1900	Copay Bypass - RHC
9861	01/01/1900	Copay Bypass - Emergency
9862	01/01/1900	Copay Bypass - Breast/Cervical Cancer
9863	10/04/2020	COPAY BYPASS - ADULT VACCINES
9880	01/01/1900	VACCINE - ADMINISTRATION FEE PAID.
9881	01/01/1900	THE PHARMACY SUBMITTED A PROFESSIONAL SERVICE CODE VALUE 'MA' FOR COVID-19 VACCINE ADMINISTRATION.
9882	01/01/1900	VACCINE - NO DISPENSING FEE PAID.
9900	01/01/1900	THE NATIONAL DRUG CODE (NDC) WAS REIMBURSED AT A GENERIC RATE.
9902	01/01/1900	PRICING ADJUSTMENT - INPATIENT PER DIEM PRICING APPLIED
9904	01/01/1900	PRICING ADJUSTMENT - MEDICARE COINSURANCE AND DEDUCTIBLE
9905	01/01/1900	MEDICARE COINSURANCE CAP RULE APPLIED
9906	01/01/1900	PRICING ADJUSTMENT - MEDICARE PRICING CUTBACKS APPLIED.
9907	01/01/1900	PRICING ADJUSTMENT - THIRD PARTY LIABILITY DEDUCTIBLE AMOUNT APPLIED.
9908	01/01/1900	PHARMACY PRICING APPLIED.
9909	01/01/1900	PRICING ADJUSTMENT - PAID ACCORDING TO PROGRAM POLICY.
9910	01/01/1900	PHARMACY DISPENSING FEE APPLIED.
9911	01/01/1900	PRICING ADJUSTMENT - LTC PER DIEM PRICING APPLIED
9912	01/01/1900	PRICING ADJUSTMENT - AMBULATORY SURGERY PRICING APPLIED.
9914	01/01/1900	PRICING ADJUSTMENT - REVENUE CODE FLAT RATE PRICING APPLIED.
9915	01/01/1900	PRICING ADJUSTMENT - MEDICARE CROSSOVER CLAIM CUTBACK APPLIED.
9916	01/01/1900	PRICING ADJUSTMENT - USUAL & CUSTOMARY CHARGE (UCC) RATE PRICING APPLIED.
9917	01/01/1900	PRICING ADJUSTMENT - MEDICARE CROSSOVER PRICED PER DIVISION OF MEDICAID POLICY.
9918	01/01/1900	PRICING ADJUSTMENT - PROCEDURE MAX FEE PRICING APPLIED

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
9919	01/01/1900	PRICING ADJUSTMENT - ZERO PAID AMOUNT OR LEVEL OF CARE PRICING APPLIED.
9920	01/01/1900	PRICING ADJUSTMENT - RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) PRICING APPLIED.
9921	01/01/1900	PRICING ADJUSTMENT - PRIOR AUTHORIZATION PRICING APPLIED.
9922	01/01/1900	PRICING ADJUSTMENT - SPENDDOWN DEDUCTIBLE APPLIED.
9923	01/01/1900	PRICING ADJUSTMENT - PATIENT LIABILITY DEDUCTION APPLIED.
9926	01/01/1900	PRICING ADJUSTMENT - MANUAL PRICING APPLIED
9927	01/01/1900	PRICING ADJUSTMENT - OBSERVATION UNITS
9928	01/01/1900	PRICING ADJUSTMENT - AMOUNT PAID IS ZERO
9929	01/01/1900	PRICING ADJUSTMENT - ANESTHESIA PRICING APPLIED.
9932	01/01/1900	PRICING ADJUSTMENT - APRDRG PRICING APPLIED
9933	01/01/1900	PRICING ADJUSTMENT - AMBULATORY PAYMENT CLASSIFICATION (APC) PRICING APPLIED.
9934	01/01/1900	PRESCRIPTION REDUCTION APPLIED.
9935	01/01/1900	PRICING ADJUSTMENT - MAXIMUM FLAT FEE PRICING APPLIED.
9936	01/01/1900	PRICING ADJUSTMENT - MAXIMUM FLAT FEE LEVEL 2 PRICING APPLIED.
9937	01/01/1900	PRICING ADJUSTMENT - USUAL & CUSTOMARY CHARGE (UCC) FLAT FEE PRICING APPLIED.
9938	01/01/1900	PRICING ADJUSTMENT - USUAL & CUSTOMARY CHARGE (UCC) FLAT FEE LEVEL 2 PRICING APPLIED.
9939	01/01/1900	FORCE-BYPASS 5% ASSESSMENT
9940	01/01/1900	EXEMPTED FROM 5% ASSESSMENT
9941	01/01/1900	PRICING ADJUSTMENT - HOSPICE LTC PER DIEM PRICING APPLIED
9942	01/01/1900	QUANTITY REDUCED BASED ON POLICY
9943	01/01/1900	SENIORCARE COST SHARE AND/OR OTHER INSURANCE PAID AMOUNT APPLIED.
9944	01/01/1900	PRICING ADJUSTMENT - INCENTIVE PRICING
9945	01/01/1900	PRICING ADJUSTMENT - REIMBURSEMENT FOR THIS CLAIM IS $0 DUE TO EITHER THE MEDICARE ALLOWED AMOUNT IS GREATER THAN THE DMAP REIMBURSEMENT AMOUNT OR THE TOTAL OF THE MEDICARE DEDUCTIBLE, COINSURANCE OR COPAYMENT IS $0.
9946	01/01/1900	PRICING ADJUSTMENT: REIMBURSEMENT AMOUNT IS THE DIFFERENCE BETWEEN THE MEDICAREALLOWED AMOUNT AND THE DMAP REIMBURSEMENT AMOUNT.
9947	01/01/1900	PRICING ADJUSTMENT: MEDICARE DEDUCTIBLE, COINSURANCE AND/OR COPAYMENT PAID IN FULL.
9948	09/01/2011	NDC WAS REIMBURSED AT AWP RATE.
9949	09/01/2011	NDC WAS REIMBURSED AT SMAC RATE.
9950	09/01/2011	NDC WAS REIMBURSED AT EMAC RATE.
9951	09/01/2011	NDC WAS REIMBURSED AT WAC RATE.
9952	09/01/2011	NDC WAS REIMBURSED AT GENERIC WAC RATE.
9953	01/01/1900	MCO ENCOUNTER DETAIL MANUALLY PRICED.
9954	01/01/1900	COST SHARE FOR ENCOUNTER PROCESSING BYPASSED.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
9955	01/01/1900	MEMBER IS NOT ENROLLED IN MANAGED CARE.
9956	01/01/1900	SERVICES HAVE BEEN CARVED OUT OF MCO ENCOUNTER PROCESSING.
9957	01/01/1900	THIS SERVICE IS NOT REIMBURSABLE FOR THE MANAGED CARE ENCOUNTER CLAIM FOR THE MEMBER'S BENEFIT PLAN.
9958	01/01/1900	NOT USED - MEMBER NOT IN ENROLLED IN DMAP, THEREFORE, THE ENCOUNT CANNOT BE PROCESSED.
9959	01/01/1900	PRICING ADJUSTMENT - ALLOWED AMOUNT CUTBACK TO BILLED - DETAIL
9960	01/01/1900	NDC WAS REIMBURSED AT NADAC RATE.
9961	01/01/1990	PRICING ADJUSTMENT SET TO ZERO
9962	01/01/1900	PRICING ADJUSTMENT - PROVIDER REVENUE RATE PRICING APPLIED
9963	01/01/1900	PRICING ADJUSTMENT - PROVIDER CLINIC RATE PRICING APPLIED
9964	01/01/1900	PRICING ADJUSTMENT - REVENUE MAX FEE PRICING APPLIED
9965	01/01/1900	PRICING ADJUSTMENT - OUTPATIENT PER DIEM PRICING APPLIED
9966	01/01/1900	PRICING ADJUSTMENT - OPPS PRICING APPLIED
9967	01/01/1900	HOSPICE TIER 1 AND TIER 2 RATES APPLY
9968	01/01/1900	PRICING ADJUSTMENT - HOSPICE TIER PRICING APPLIED
9969	01/01/1900	PRICING ADJUSTMENT - ALLOWED AMOUNT CUTBACK TO BILLED - HEADER
9970	01/01/1900	PRICING ADJUSTMENT - PPECC ADD-ON
9971	01/01/1900	PRICING ADJUSTMENT - NURSE PRACTITIONER CUTBACK
9972	01/01/1900	PRICING ADJUSTMENT - GROUP SCHOOL SERVICES CUTBACK
9973	01/01/1900	PRICING ADJUSTMENT - ASSISTANT SURGEON CUTBACK
9974	01/01/1900	PRICING ADJUSTMENT - CO-SURGEON CUTBACK
9975	01/01/1900	PRICING ADJUSTMENT - POSTOPERATIVE MANAGEMENT ONLY CUTBACK
9976	01/01/1900	PRICING ADJUSTMENT - SURGICAL PROCEDURE ONLY CUTBACK
9977	01/01/1900	PRICING ADJUSTMENT - MEDICALLY DIRECTED ANESTHESIA CUTBACK
9978	01/01/1900	PRICING ADJUSTMENT - NON-MEDICALLY DIRECTED ANESTHESIA CUTBACK
9979	01/01/1900	PRICING ADJUSTMENT - MULTIPLE ANESTHESIA PRICING
9980	01/01/1900	PRICING ADJUSTMENT - BILATERAL PROCEDURE ADD-ON
9981	01/01/1900	PRICING ADJUSTMENT - BILATERAL/MULTIPLE SURGERY PRICING APPLIED
9982	01/01/1900	PRICING ADJUSTMENT - OPPS BILATERAL/MULTIPLE PROCEDURE PRICING APPLIED
9983	01/01/1900	PRICING ADJUSTMENT - MULTIPLE LESION PRICING
9984	01/01/1900	PRICING ADJUSTMENT - MULTIPLE DELIVERY PRICING
9986	01/01/1900	PRICING ADJUSTMENT - MEDICAL EDUCATION ADD-ON
9987	01/01/1900	PRICING ADJUSTMENT - BENEFIT ADJUSTMENT FACTOR (BAF) APPLIED (BEFORE GTB)
9988	01/01/1900	PRICING ADJUSTMENT - BENEFIT ADJUSTMENT FACTOR (BAF) APPLIED (AFTER GTB)
9989	01/01/1900	PRICING ADJUSTMENT - 5% ASSESSMENT
9998	01/01/1900	PRICING ADJUSTMENT - CUTBACK APPLIED
9999	01/01/1900	PROCESSED PER POLICY