Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0000	1/1/1900	THIS CLAIM/SERVICE IS PENDING FOR PROGRAM REVIEW.
0001	1/1/1900	NOT USED - MEMBER'S DMAP I.D. NUMBER IS MISSING OR INCORRECT
0002	1/1/1900	COULD NOT PROCESS CLAIM. PLEASE RESUBMIT CLAIM LATER.
0003	1/1/1900	A MINIMUM OF ONE DETAIL IS REQUIRED.
0004	1/1/1900	DME RENTAL BEYOND THE INITIAL 30 DAY PERIOD IS NOT PAYABLE WITHOUT PRIOR AUTHORIZATION.
0007	1/1/1900	INFORMATION INADEQUATE TO ESTABLISH MEDICAL NECESSITY OF PROCEDURE PERFORMED.PLEASE RESUBMIT WITH ADDITIONAL SUPPORTING DOCUMENTATION.
0008	1/1/1900	Paper claims submitted prior to Oct. 3, 2022, and remaining unprocessed as of Oct. 3, 2022, were converted and processed as electronic claims.
0010	1/1/1900	MEMBER IS ENROLLED IN MEDICARE PART A AND/OR PART B ON THE DISPENSE DATE OF SERVICE.
0014	1/1/1900	DISCREPANCY EXISTS BETWEEN OTHER COVERAGE CODE AND THE OTHER PAYER PAID AMOUNT.
0015	1/1/1900	MEMBER IS ENROLLED IN MEDICARE PART D ON THE DATE(S) OF SERVICE.
0019	1/1/1900	MEDICARE PAID THE TOTAL ALLOWABLE FOR THE SERVICE.
0021	1/1/1900	PROCEDURE CODE IS ALLOWED ONCE PER MEMBER PER LIFETIME.
0022	1/1/1900	BILLING PROVIDER NPI AND TAXONOMY COMBINATION IS INVALID. RESUBMIT WITH THE VALID ENROLLED TAXONOMY.
0024	1/1/1900	PROVIDER ON PREPAYMENT REVIEW
0025	1/1/1900	BILLING PROVIDER IS NO LONGER ENROLLED FOR THE FROM AND/OR TO DATE OF SERVICE.
0029	1/1/1900	LAST NAME DOES NOT MATCH MEMBER ID.
0030	1/1/1900	PRESCRIBING/REFERRING/ORDERING PROVIDER IS NOT CURRENTLY ENROLLED.
0031	1/1/1900	PROCEDURE CONVERSION FACTOR MISSING FOR RBRVS PROCEDURE CODE.
0033	1/1/1900	THE MEMBER WAS NOT ELIGIBLE FOR THE DATE OF SERVICE ON YOUR CLAIM.
0037	1/1/1900	CLAIM DENIED. CONSENT FOR STERILIZATION/HYSTERECTOMY ACKNOWLEDGEMENT/ABORTION NECESSITY FORM IS MISSING, INCOMPLETE, OR CONTAINS INVALID INFORMATION.
0039	1/1/1900	NOT USED - THE SERVICE REQUESTED IS NOT A COVERED BENEFIT OF THE DMAP PROGRAM.
0040	1/1/1900	RENDERING PROVIDER ID IS NOT ON FILE.
0044	1/1/1900	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
0045	1/1/1900	NOT USED - THE SERVICE REQUESTED DOES NOT CORRESPOND WITH DMAP AGE CRITERIA.
0047	1/1/1900	THESE CASE COORDINATION SERVICES EXCEED THE LIMIT.
0049	1/1/1900	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	1/1/1900	THE HEADER FROM AND TO DATES OF SERVICE CANNOT BE THE SAME.
0052	1/1/1900	THE ADMIT DATE IS REQUIRED.

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EOB Code	Effective Date	Description
0056	1/1/1900	FUTURE DATE OF SERVICE NOT ALLOWED.
0058	1/1/1900	PROCEDURE BILLED IS NOT ON THE RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) FILE.
0060	1/1/1900	ADMIT DIAGNOSIS IS REQUIRED.
0064	1/1/1900	CLAIM REDUCED TO FIFTEEN HOSPITAL BEDHOLD DAYS FOR STAYS EXCEEDING FIFTEEN DAYS.
0074	1/1/1900	BILLING PROVIDER IS RESTRICTED FROM SUBMITTING ELECTRONIC CLAIMS.
0077	1/1/1900	REND PROV CONTRACT NOT VALID ON DOS - DTL
0080	1/1/1900	DIAGNOSIS CODE SUBMITTED IS NOT APPROPRIATE FOR SERVICE BILLED.
0081	1/1/1900	NOT USED - AMOUNT PAID BY OTHER INSURANCE EXCEEDS AMOUNT ALLOWED BY DMAP.
0082	1/1/1900	PRIOR AUTHORIZATION NUMBER CHANGED TO PERMIT APPROPRIATE CLAIMS PROCESSING.
0084	1/1/1900	PROVIDER SIGNATURE AND/OR DATE REQUIRED.
0086	1/1/1900	CLAIM CANNOT CONTAIN BOTH CONDITION CODES A5 AND X0 ON THE SAME CLAIM. PLEASERESUBMIT CHARGES FOR EACH CONDITION CODE ON A SEPARATE CLAIM.
0091	1/1/1900	A VALID ENROLLED PRESCRIBING/REFERRING/ORDERING PROVIDER NPI IS REQUIRED.
0093	1/1/1900	FIRST MODIFIER CODE IS INVALID FOR DATE OF SERVICE.
0094	1/1/1900	REFILL INDICATOR MISSING OR INVALID. PLEASE CORRECT AND RESUBMIT.
0095	1/1/1900	DAW NOT ACCEPTED.
0100	1/1/1900	DENIED AS DUPLICATE CLAIM. SERVICES ON THIS CLAIM WERE PREVIOUSLY PARTIALLY PAID OR PAID IN FULL.
0101	1/1/1900	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	1/1/1900	DUPLICATE ITEM OF A CLAIM BEING PROCESSED. PLEASE DO NOT FILE A DUPLICATE CLAIM.
0106	1/1/1900	INVALID MEDICARE DISCLAIMER SUBMITTED.
0110	1/1/1900	NOT USED - BENEFIT PAYMENT DETERMINED BY DMAP FISCAL AGENT REVIEW.
0112	1/1/1900	SERVICE CODE IS INVALID.
0114	1/1/1900	SCHEDULE 3, 4, 5 DRUGS LIMITED TO ORIGINAL FILL PLUS 5 REFILLS OR 6 MONTHS.
0115	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST.
0116	1/1/1900	PROCEDURE CODE IS NOT A BENEFIT ON DATE OF SERVICE.
0119	1/1/1900	YOU ARE BILLING FOR DATES OF SERVICE THAT SPAN PROGRAMS. CHECK ELIGIBILITY ANDRESUBMIT AS SEPARATE CLAIMS.
0120	1/1/1900	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAVEBEEN REDUCED.
0127	1/1/1900	RENDERING PROVIDER IS NOT ENROLLED UNDER BILLING GROUP NUMBER FOR DATES OF SERVICE BILLED
0128	1/1/1900	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
0130	1/1/1900	MEMBER HAS MEDICARE SUPPLEMENTAL COVERAGE FOR THE DATE(S) OF SERVICE.
0133	1/1/1900	THE ADMIT TYPE CODE IS INVALID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0135	1/1/1900	DAW REQUIRED FOR BRAND INNOVATOR NDC.
0146	1/1/1900	NON-SCHEDULED DRUGS LIMITED TO ORIGINAL DISPENSING PLUS 11 REFILLS OR 12 MONTHS.
0148	1/1/1900	DISPENSING REPLACEMENT PARTS AND COMPLETE APPLIANCE ON SAME DATE OF SERVICE NOTALLOWED.
0152	1/1/1900	MEDICARE PAID AMOUNT(S) HAVE BEEN INCORRECTLY APPLIED TO BOTH THE CLAIM HEADERAND DETAILS.
0153	1/1/1900	THE HEADER TOTAL BILLED AMOUNT IS INVALID.
0156	1/1/1900	THE MEDICARE PAID AMOUNT IS MISSING OR INCORRECT.
0158	1/1/1900	QUANTITY BILLED IS MISSING OR EXCEEDS THE MAXIMUM ALLOWED PER DATE OF SERVICE.
0159	1/1/1900	A VALID HEADER MEDICARE PAID DATE IS REQUIRED.
0160	1/1/1900	MEDICARE ALLOWED AMOUNT WAS INCORRECT OR NOT PROVIDED ON CROSSOVER CLAIM.
0162	1/1/1900	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	1/1/1900	FREQUENCY OR NUMBER OF INJECTIONS EXCEED PROGRAM POLICY GUIDELINES.
0166	1/1/1900	THE PROCEDURE CODE BILLED NOT PAYABLE ACCORDING TO DEFRA.
0171	1/1/1900	CLAIM OR ADJUSTMENT RECEIVED BEYOND 365-DAY FILING DEADLINE.
0172	1/1/1900	MEMBER IS NOT ENROLLED FOR ALL DATES OF SERVICE BILLED.
0174	1/1/1900	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	1/1/1900	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
0177	1/1/1900	A PLACE OF SERVICE CODE IS REQUIRED.
0182	1/1/1900	BILLING PROVIDER TYPE AND/OR SPECIALTY IS NOT ALLOWABLE FOR THE SERVICE BILLED.
0183	1/1/1900	PROVIDER NOT AUTHORIZED TO PERFORM PROCEDURE.
0184	1/1/1900	PROCEDURE CODE IS RESTRICTED BY MEMBER AGE.
0185	1/1/1900	PROCEDURE CODE BILLED IS NOT APPROPRIATE FOR MEMBER'S GENDER.
0186	1/1/1900	VISION EXAM LIMITED TO ONE PER YEAR.
0192	1/1/1900	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	1/1/1900	BILLING PROVIDER ID MISSING
0201	1/1/1900	RENDERING PROVIDER IS NOT CERTIFIED FOR THE DATE(S) OF SERVICE.
0202	1/1/1900	TABLET SPLITTING LIMITED TO 3 FEES, PER MEMBER, PER MONTH.
0203	1/1/1900	DAYS SUPPLY IS INVALID.
0205	1/1/1900	DETAIL RENDERING PROVIDER IS NO LONGER ENROLLED FOR THE DATE OF SERVICE
0208	1/1/1900	PREGNANCY INDICATOR INVALID

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0210	1/1/1900	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	1/1/1900	PROCEDUE CODE IS ALLOWED ONCE PER MEMBER PER CALENDAR YEAR.
0213	1/1/1900	THE SERVICE(S) BILLED ARE CONSIDERED PAID IN THE PAYMENT FOR THE SURGICAL PROCEDURE.
0218	1/1/1900	PRIOR AUTHORIZATION IS REQUIRED FOR SERVICE(S) EXCEEDING MENTAL HEALTH AND/OR SUBSTANCE ABUSE BENEFIT GUIDELINES.
0220	1/1/1900	TOOTH SURFACE IS INVALID OR NOT INDICATED.
0221	1/1/1900	THE DETAIL BILLED AMOUNT IS REQUIRED.
0224	1/1/1900	QUANTITY DISPENSED IS INVALID.
0226	1/1/1900	WELL-BABY VISITS ARE LIMITED TO 12 VISITS IN THE FIRST YEAR OF LIFE.
0229	1/1/1900	THE TYPE OF BILL IS INVALID.
0232	1/1/1900	SOURCE OF ADMIT IS MISSING OR INVALID.
0235	1/1/1900	DENIED/CUTBACK. PURCHASE OF ADDITIONAL DME/DMS ITEM EXCEEDING LIFE EXPECTANCY REQUIRES PRIOR AUTHORIZATION.
0238	1/1/1900	MEMBER ID CREATED FOR NEWBORN (K-BABY).
0240	1/1/1900	THE PRESCRIPTION REFILL NUMBER (FILL NUMBER) IS NOT NUMERIC.
0242	1/1/1900	PRESCRIPTION DATE IS INVALID.
0245	1/1/1900	NO DRUG REBATE AGREEMENT.
0247	1/1/1900	PROCEDURE CODE HAS BEEN TERMINATED BY CMS, AMA OR ADA FOR THE DATE OF SERVICE.
0250	1/1/1900	CLAIM HAS NO DETAILS
0254	1/1/1900	A VALID DETAIL MEDICARE PAID DATE IS REQUIRED
0259	1/1/1900	DATE BILLED IS MISSING/INVALID
0262	1/1/1900	TOOTH NUMBER IS INVALID
0263	1/1/1900	PRIOR AUTHORIZATION IS REQUIRED FOR MANIPULATIONS/ADJUSTMENTS EXCEEDING 20 PERSPELL OF ILLNESS.
0264	1/1/1900	SUBSEQUENT SURGICAL PROCEDURES ARE REIMBURSED AT REDUCED RATE.
0268	1/1/1900	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	1/1/1900	RESUBMIT CHARGES FOR MEDICAID COVERED SERVICE(S) DENIED BY MEDICARE ON A MEDICAID CLAIM
0274	1/1/1900	COMPLEX CARE OF 17-PLUS HOURS AND COMPLEX CARE OF LESS THAN 17 HOURS ARE NOT ALLOWED ON THE SAME DATE OF SERVICE.
0275	1/1/1900	ADJUSTMENT/RECONSIDERATION REQUEST DENIED DUE TO INCORRECT/INSUFFICIENT INFORMATION. REVIEW BILLING INSTRUCTIONS. USE THIS CLAIM NUMBER IF YOU RESUBMIT.
0276	1/1/1900	THE SUM OF ALL VALUE CODE AMOUNTS MUST BE NUMERIC AND LESS THAN OR EQUAL TO 999.999.999.
0277	1/1/1900	NDC/PHARMACEUTICAL CARE INCLUDED IN NURSING HOME DAILY RATE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0278	1/1/1900	MEMBER IS COVERED BY A COMMERCIAL HEALTH INSURANCE ON THE DATE(S) OF SERVICE. RESUBMIT WITH EOB.
0281	1/1/1900	MEMBER ID IS REQUIRED.
0282	1/1/1900	INPATIENT PSYCHIATRIC SERVICES ARE NOT REIMBURSABLE FOR MEMBERS AGE 21 - 65 (AGE 22 IF RECEIVING SERVICES PRIOR TO 21ST BIRTHDAY).
0285	1/1/1900	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	1/1/1900	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	1/1/1900	THE REVENUE/HCPCS CODE COMBINATION IS INVALID.
0289	1/1/1900	OUT-OF-STATE NON-EMERGENCY SERVICES REQUIRE PRIOR AUTHORIZATION.
0295	1/1/1900	DOES NOT MEET HEARING AID PERFORMANCE CHECK REQUIREMENT OF 45 POST DISPENSING DAYS.
0303	1/1/1900	THE DATE OF THE SCREENING REQUEST OR THE DATE OF SCREENING IS INVALID OR MISSING. PLEASE CORRECT AND RESUBMIT.
0304	1/1/1900	HOSPICE UNITS BILLED ARE GREATER THAN DETAIL COVERED DATESPAN
0309	1/1/1900	CONSULTATION OR SURGICAL PROCEDURES ARE NOT REIMBURSABLE IN CONJUCTIONS WITH EMERGENCY ROOM SERVICES.
0310	1/1/1900	THE SPECIAL PACKAGING INDICATOR/UNIT DOSE INDICATOR IS INVALID
0316	1/1/1900	BACK-UP DIALYSIS SESSIONS ARE LIMITED TO THREE PER LIFETIME.
0319	1/1/1900	FOUR X-RAYS ARE ALLOWED PER SPELL OF ILLNESS PER PROVIDER.RECONSIDERATION WITH DOCUMENTATION WARRANTING MORE X-RAYS.
0320	1/1/1900	PCN ONLY REQUIRED FOR SENIORCARE/WCDP.
0321	1/1/1900	ORAL EXAMS OR PROPHYLAXIS IS LIMITED TO ONCE PER YEAR UNLESS PRIOR AUTHORIZED.
0325	1/1/1900	SERVICES HAVE BEEN DETERMINED BY DHCAA TO BE NON-EMERGENCY.
0334	1/1/1900	INPATIENT MENTAL HEALTH SERVICES PERFORMED BY MASTER'S LEVEL PSYCHOTHERAPISTS OR SUBSTANCE ABUSE COUNSELORS ARE NOT COVERED.
0335	1/1/1900	THE COMPREHENSIVE COMMUNITY SUPPORT PROGRAM REIMBURSEMENT LIMITATIONS HAVE BEENEXCEEDED.
0336	1/1/1900	REIMBURSEMENT LIMITS FOR COMMUNITY CARE SERVICES FOR THE CALENDAR YEAR ARE CLOSE TO BEING EXCEEDED.
0344	1/1/1900	MEDICATION CHECKS BY A PSYCHIATRIST AND/OR REGISTERED NURSE ARE LIMITED TO FOURSERVICES PER CALENDAR MONTH.
0350	1/1/1900	REIMBURSEMENT IS LIMITED TO ONE "MAXIMUM ALLOWABLE FEE" PER DAY PER PROVIDER.
0361	1/1/1900	DISPENSING FEE DENIED. ONLY TWO DISPENSING FEES PER MONTH, PER MEMBER ALLOWED.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0365	1/1/1900	CLAIM DENIED/CUTBACK. PURCHASE OF A DME/DMS ITEM EXCEEDING ONE PER MONTH REQUIRES PRIOR AUTHORIZATION.
0366	1/1/1900	NON-PREFERRED DRUGS REQUIRE PA.
0369	1/1/1900	34 DAYS SUPPLY OR LESS REQUIRED FOR NDC.
0376	1/1/1900	DAYS SUPPLY EXCEEDS ALLOWED LIMIT.
0378	1/1/1900	TOOTH NUMBER OR LETTER IS NOT VALID WITH THE PROCEDURE CODE FOR THE DATE OF SERVICE.
0386	1/1/1900	EYEGLASSES LIMITED TO ORIGINAL PLUS 1 REPLACEMENT PAIR, LENS OR FRAME IN 12 WITHOUT PRIOR AUTHORIZATION.
0388	1/1/1900	A VALID PROCEDURE CODE IS REQUIRED.
0389	1/1/1900	HEADER FROM DATE OF SERVICE IS REQUIRED.
0398	1/1/1900	A VALID PRIOR AUTHORIZATION IS REQUIRED.
0399	1/1/1900	DATE OF SERVICE MUST FALL BETWEEN THE PRIOR AUTHORIZATION GRANT DATE AND EXPIRATION DATE.
0402	1/1/1900	CLAIM OR ADJUSTMENT/RECONSIDERATION REQUEST MUST HAVE BOTH A REVENUE CODE AND EITHER A HCPCS CODE OR CPT CODE.
0404	1/1/1900	THE MEMBER HAS NO LEVEL OF CARE (LOC) AUTHORIZATION ON FILE.
0408	1/1/1900	THE DIAGNOSIS CODE IS NOT COVERED FOR THE MEMBER.
0409	1/1/1900	NO REIMBURSEMENT RATES ON FILE FOR THE DATE(S) OF SERVICE.
0411	1/1/1900	TIMELY FILING DEADLINE EXCEEDED. NO SUPPORTING DOCUMENTATION. PLEASE REFER TO THE ALL PROVIDER HANDBOOK FOR INSTRUCTIONS.
0413	1/1/1900	INITIAL VISIT/EXAM LIMITED TO ONCE PER LIFETIME PER PROVIDER.
0414	1/1/1900	REIMBURSEMENT OF THIS SERVICE IS INCLUDED IN THE REIMBURSEMENT OF THE MOST COMPLEX/COMPLETE PROCEDURE PERFORMED.
0415	1/1/1900	PAYMENT REDUCED. ALL RENTAL PAYMENTS HAVE BEEN DEDUCTED FROM THE PURCHASE COSTSINCE THE DME ITEM WAS RENTED AND SUBSEQUENTLY PURCHASED FOR THE MEMBER.
0416	1/1/1900	SERVICE DENIED, REFER TO MEDICARE'S BILLING AND/OR POLICY GUIDELINES.
0420	1/1/1995	PRESCRIBER REQUIRED TO CONTACT DAPO FOR OVERRIDE TO EXCEED 5 OPIOID RXS/MONTH.
0421	1/1/1995	BENCHMARK PLAN, CORE PLAN AND BASIC PLAN LIMITED TO 5 OPIOID RXS/MONTH.
0422	1/1/1900	MEMBER LIMITED TO ONE ANTIPSYCHOTIC DRUG/MONTH. ATTESTATION REQUIRED TO EXCEED.
0423	1/1/1900	ANTIPSYCHOTIC PA REQUIRED FOR CHILDREN.
0424	1/1/1900	BILLING PROVIDER ID IS NOT ON FILE.
0428	1/1/1900	TRAUMA/ACCIDENT CLAIM
0433	1/1/1900	MEDICARE DEDUCTIBLE AMOUNT INVALID
0434	1/1/1900	MEDICARE COINSURANCE AMOUNT INVALID
0439	1/1/1900	SERVICE(S) PAID AT THE MAXIMUM DAILY AMOUNT PER PROVIDER PER MEMBER.
0440	1/1/1900	HEARING AID REPAIRS ARE LIMITED TO ONCE PER SIX MONTHS, PER PROVIDER, PER HEARING AID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0443	1/1/1900	REPAIR SERVICES BILLED IN EXCESS OF THE AMOUNT SPECIFIED IN THE DURABLE MEDICALEQUIPMENT (DME) HANDBOOK REQUIRE PRIOR AUTHORIZATION.
0446	1/1/1900	THIS SERVICE IS PAYABLE AT A FREQUENCY OF ONCE PER 12-MONTH PERIOD, PER PROVIDER, PER HEARING AID.
0455	1/1/1900	DATE(S) OF SERVICE ON DETAIL MUST BE WITHIN A SUNDAY THRU SATURDAY CALENDAR WEEK.
0473	1/1/1900	ONE OR MORE ICD PROCEDURE CODE IS INVALID IN POSITIONS 6-24
0477	1/1/1900	BILLING PROVIDER INDICATED IS NOT CERTIFIED AS A BILLING PROVIDER.
0485	1/1/1900	QUANTITY LIMIT EXCEEDED.
0491	1/1/1900	TO ALLOW FOR MEDICARE PRICING CORRECT DETAIL DENIALS AND RESUBMIT.
0495	1/1/1900	RESUBMIT WITH LEGIBLE MEDICARE EOMB SHOWING VALID PAID DATE.
0498	1/1/1900	PHARMACEUTICAL CARE MUST BE BILLED WITH A LEVEL OF EFFORT.
0503	1/1/1900	MEMBER IS ENROLLED IN MEDICARE PART C ON THE DATE(S) OF SERVICE.
0505	1/1/1900	MEMBER OVER 65 BILL MEDICARE
0506	1/1/1900	DATE BILLED IS AFTER ICN
0509	1/1/1900	BILLED AND ALLOWED AMOUNTS EXCEED A VARIANCE THRESHOLD.
0510	1/1/1900	A VALID PRIOR AUTHORIZATION IS REQUIRED.
0511	1/1/1900	THIS NATIONAL DRUG CODE (NDC) IS ONLY PAYABLE AS PART OF A COMPOUND DRUG.
0513	1/1/1900	THIS CLAIM WAS PROCESSED AS A MEDICARE C ADVANTAGE PLAN CLAIM.
0521	1/1/1900	NOT USED - THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVEREDBY DMAP.
0540	1/1/1900	CLAIM IS LOCKED FROM VOIDS OR ADJUSTMENTS
0541	1/1/1900	CLAIM IS LOCKED FROM ADJUSTMENTS
0543	1/1/1900	PLEASE INDICATE QUANTITY DISPENSED.
0545	1/1/1900	MEMBER ENROLLED IN MEDICARE PART D. SUBMIT CLAIM TO MEDICARE PART D PLAN.
0558	1/1/1900	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
0570	1/1/1900	HEADER TOTAL DAYS ARE LESS THAN COVERED DAYS
0573	1/1/1900	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
0585	1/1/1900	FAMILY PLANNING INDICATOR IS INVALID.
0587	1/1/1900	SUPPLEMENTAL TESTS BILLED ON THE SAME DATE OF SERVICE AS VISION EXAMINATION ARENOT PAYABLE.
0589	1/1/1900	QTY AND/OR DETAIL CHARGE DO NOT DIVIDE OUT EQUALLY FOR DATES OF SERVICE AND/ORQTY GIVEN.
0592	1/1/1900	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	1/1/1900	BILLING PROVIDER IS NOT CERTIFIED FOR SUBSTANCE ABUSE DAY TREATMENT FOR THE DATE(S) OF SERVICE.
0595	1/1/1900	THE SERVICE WAS PREVIOUSLY PAID FOR THIS DATE OF SERVICE.
0599	1/1/1900	ATTACHMENT CONTROL NUMBER IS MISSING. RESUBMIT WITH AN ATTACHMENT CONTROL NUMBER.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0609	1/1/1900	ANCILLARY CODES ARE REIMBURSABLE ONLY FOR PAYABLE IN-HOUSE ACCOMMODATION DATESOF SERVICE.
0610	1/1/1900	DELIVERY ROOM UNITS EXCEED LIMIT OF ONE PER DAY
0611	1/1/1900	FIRST TWO CHARACTERS (SUB-CONTRACTOR ID) OF THE CCO ICN IS MISSING OR INVALID
0613	1/1/1900	SERVICES SUBMITTED ON IMPROPER CLAIM FORM. REBILL USING CORRECT CLAIM FORM AS INSTRUCTED IN YOUR HANDBOOK.
0614	1/1/1900	FIRST NAME DOES NOT MATCH MEMBER ID.
0616	1/1/1900	CCO DENIED CHIP ENCOUNTERS BASED ON CAS RSN CODES
0618	1/1/1900	REPACKAGING NOT ALLOWED FOR NDC.
0619	1/1/1900	CCO CHP BLN PROVIDER NOT FOUND ON AFFILIATION FILE
0620	1/1/1900	CONTINUOUS HOME CARE MUST BE BILLED IN AN HOURLY QUANTITY EQUAL TO OR GREATER THAN EIGHT HOURS, UP TO AND INCLUDING 24 HOURS.
0621	1/1/1900	HOSPICE MEMBER SERVICES RELATED TO THE TERMINAL ILLNESS MUST BE BILLED BY HOSPICE OR ATTENDING PHYSICIAN.
0622	1/1/1900	CONTINUOUS HOME CARE AND ROUTINE HOME CARE MAY NOT BE BILLED FOR THE SAME MEMBER ON THE SAME DATE OF SERVICE.
0627	1/1/1900	DOCUMENTATION TO DETERMINE MEDICAL NECESSITY REQUIRED.
0628	1/1/1900	Missing or Invalid COB Paid Amount
0629	1/1/1900	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	1/1/1900	NOT A SPECIALTY DRUG, AS THIS DRUG HAS A NADAC PRICE
0631	1/1/1900	MEMBER ASSIGNED TO LOCK-IN PROGRAM.
0633	1/1/1900	CLOZAPINE MANAGEMENT IS LIMITED TO ONE HOUR PER SEVEN-DAY TIME PERIOD PER PROVIDER PER MEMBER.
0635	1/1/1900	AMITIZA 8 MCG IS INDICATED FOR TREATMENT OF IRRITABLE BOWEL SYNDROME CONSTIPATION IS FEMALES ONLY.
0636	1/1/1900	PROGRAM CLAIM LIMIT EXCEEDED.
0637	1/1/1900	OTHER PAYER AMOUNT PAID CANNOT BE A NEGATIVE AMOUNT
0638	1/1/1900	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	1/1/1900	CLINICIAN ADMINISTERED DRUGS AND DEVICES- BILLED WITH PLACE OF SERVICE 11.
0640	1/1/1900	THE MAXIMUM NUMBER OF DETAILS IS EXCEEDED.
0643	1/1/1900	BILLING PROVIDER IS NOT CERTIFIED FOR THE DETAIL FROM DATE OF SERVICE.
0645	1/1/1900	THE PAYER ID DOES NOT MATCH THE CARRIER CODE ON THE CARRIER TABLE.
0646	1/1/1900	BENEFICIARY IS PREGNANT (PREGNANCY INDICATOR = 2) BUT THE GENDER OF THE BENEFICIARY IS NOT FEMALE.
0651	1/1/1900	ONE RN HH/RN SUPERVISORY VISIT IS ALLOWED PER DATE OF SERVICE PER PROVIDER PERMEMBER.
0652	1/1/1900	SUPERVISORY VISITS FOR UNSKILLED CASES ALLOWED ONCE PER 60-DAY PERIOD.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0653	1/1/1900	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.
0656	1/1/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE FIRST DIAGNOSIS CODE.
0657	1/1/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE SECOND DIAGNOSIS CODE.
0658	1/1/1900	THE QUANTITY BILLED FOR THIS SERVICE MUST BE IN WHOLE OR HALF HOUR INCREMENTS(.5) INCREMENTS.
0659	1/1/1900	DENTAL SERVICE IS LIMITED TO ONCE EVERY SIX MONTHS WITHOUT PRIOR AUTHORIZATION(PA).
0664	1/1/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE THIRD DIAGNOSIS CODE.
0668	1/1/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE FOURTH DIAGNOSIS CODE.
0669	1/1/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE FIFTH DIAGNOSIS CODE.
0670	1/1/1900	COMPOUND DRUG REQUIRES PA
0671	1/1/1900	DENIED/CUBACK. RISK ASSESSMENT/CARE PLAN IS LIMITED TO ONE PER MEMBER PER PREGNANCY.
0672	1/1/1900	USUAL CUSTOMARY CHRG-TOTAL CHG AMT-MISSING OR ZERO
0673	1/1/1900	MORE THAN 3 DAYS SUPPLY NOT ALLOWED FOR 72 HOUR EMERGENCY
0674	1/1/1900	THIS NDC IS A NONPREFERRED PACKAGE SIZE. SEE PDL FOR PREFERRED PKG. SIZE.
0675	1/1/1900	MISSING OR INVALID CCO ALLOWED AMOUNT
0676	1/1/1900	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	1/1/1900	INVALID DAYS SUPPLY
0678	1/1/1900	BILLING PROVIDER TYPE AND SPECIALTY IS NOT ALLOWABLE FOR THE RENDERING PROVIDER.
0679	1/1/1900	THE SURGICAL PROCEDURE CODE OF GREATEST SPECIFICITY MUST BE USED.
0680	1/1/1900	COST EXCEEDS MAX ALLOWED/CLAIM ($1000.00-$4999.99)
0681	1/1/1900	COST EXCEEDS MAX ALLOWED PER CLAIM (>=$5000.00).
0682	1/1/1900	BILL INJECTABLE SCHEDULE II DRUGS ON A MEDICAL CLAIM FORM
0683	1/1/1900	GENERIC DRUG REQUIRED. IF BRAND IS MEDICALLY NECESSARY PRESCRIBER MUST SUBMIT PA REQUEST.
0685	1/1/1900	QUANTITY PRESCRIBED REQUIRED WHEN BILLING DEA SCHEDULE II DRUGS
0689	1/1/1900	NEUPOGEN SYRINGES ARE NON-PREFERRED. PLEASE DISPENSE PREFFERRED NEUPOGEN VIALS.
0690	1/1/1900	PA REQUIRED FOR NONPREFERRED DRUG
0691	1/1/1900	INSULIN PEN NON PREFERRED IN LTC
0692	1/1/1900	M/I USUAL & CUSTOMARY CHARGE

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0693	1/1/1900	THIS DENTAL SERVICE LIMITED TO ONCE PER FIVE YEARS.PRIOR AUTHORIZATION IS NEEDED TO EXCEED THIS LIMIT.
0695	1/1/1900	PA REQUIRED FOR NON-PREFERRED BRAND. PRESCRIBER MAY SUBMIT BRAND MEDICALLY NECESSARY PA REQUEST.
0696	1/1/1900	COMPOUND CLAIM AND MISSING OR INVALID ROUTE OF ADMINISTRATION
0697	1/1/1900	THE NUMBER OF TOOTH SURFACES INDICATED IS INSUFFICIENT FOR THE PROCEDURE CODE BILLED.
0698	1/1/1900	MEMBER IS NOT ENROLLED FOR THE DATE(S) OF SERVICE.
0699	1/1/1900	INGREDIENT COST OF THIS 340B DRUG MUST BE SUBMITTED
0700	1/1/1900	DIAGNOSIS TREATMENT INDICATOR IS INVALID.
0701	9/1/2020	SCC INVALID FOR DOUBLE DOSE AND BOOSTER COVID VACCINES.
0702	9/1/2020	VACCINES REQUIRE PROFESSIONAL SERVICE CODE MA
0703	1/1/1900	INCENTIVE AMOUNT SUBMITTED FOR VACCINE ADMINISTRATION DOES NOT MATCH ALLOWED ADMINISTRATION FEE.
0704	1/1/1900	ADULT NON-COVID VACCINES ARE NOT COVERED FOR LONG TERM CARE (LTC) MEMBERS
0705	1/1/1900	HEALTHCHECK SCREENINGS OR OUTREACH IS LIMITED TO SIX PER YEAR FOR MEMBERS UP TOONE YEAR OF AGE.
0706	1/1/1900	HEALTHCHECK SCREENINGS OR OUTREACH LIMITED TO THREE PER YEAR FOR MEMBERS BETWEEN THE AGE OF ONE AND TWO YEARS.
0707	1/1/1900	HEALTHCHECK SCREENINGS OR OUTREACH LIMITED TO TWO PER YEAR FOR MEMBERS BETWEENTHE AGES OF TWO AND THREE YEARS.
0708	1/1/1900	HEALTHCHECK SCREENINGS/OUTREACH LIMITED TO ONE PER YEAR FOR MEMBERS AGE 3 OR OLDER.
0709	1/1/1900	ONE VISIT ALLOWED PER DAY, SERVICE DENIED AS DUPLICATE.
0710	1/1/1900	MEMBER SPI INDICATOR SET FOR DOS
0711	9/1/2020	COVID VACCINE SUBMITTED WITH PROFESSIONAL SERVICE CODE MA
0712	1/1/1900	THE CLAIM SUBMITTED IS OUTSIDE THE ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM.
0716	1/1/1900	THE VALUE CODE AND/OR VALUE CODE AMOUNT IS MISSING, INVALID OR INCORRECT.
0718	1/1/1900	REFERRING PROVIDER NUMBER MISSING OR INVALID
0719	1/1/1900	ADMISSION DATE DOES NOT MATCH THE HEADER FROM DATE OF SERVICE.
0720	1/1/1900	BILLING PROVIDER IS NOT CERTIFIED FOR THE DATE(S) OF SERVICE.
0721	1/1/1900	INVALID USE OF BILATERAL PROCEDURE MODIFIER
0722	1/1/1900	Invalid use of Multiple Procedure Modifier (51)
0723	1/1/1900	INVALID USE OF THE TWO SURGEONS MODIFIER (62)
0725	1/1/1900	OUTPATIENT DATE BUNDLING NOT ALLOWED
0726	1/1/1900	OUTPATIENT DATE BUNDLING LIMIT EXCEEDED
0730	1/1/1900	ONLY THE INITIAL BASE RATE IS PAYABLE WHEN WAITING TIME IS BILLED IN CONJUNCTION WITH A ROUND TRIP.
0733	1/1/1900	DAY TREATMENT EXCEEDING 120 HOURS PER MONTH IS NOT PAYABLE REGARDLESS OF PRIORAUTHORZATION

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0737	1/1/1900	PAID IN ACCORDANCE WITH DENTAL POLICY GUIDE DETERMINED BY DHS.
0745	1/1/1900	REIMBURSEMENT FOR MYCOTIC PROCEDURES IS LIMITED TO SIX DATES OF SERVICE PER CALENDAR YEAR.
0746	1/1/1900	ROUTINE FOOT CARE IS LIMITED TO NO MORE THAN ONCE EVERY 61DAYS PER MEMBER.
0749	1/1/1900	ROUTINE FOOT CARE DIAGNOSES MUST BE BILLED WITH VALID ROUTINE FOOT CARE PROCEDURE CODES.
0752	1/1/1900	INPATIENT ADMISSION LESS THAN 24 HOURS, REBILL AS OUTPATIENT
0770	1/1/1900	THE REVENUE CODE IS NOT ALLOWED FOR THE TYPE OF BILL INDICATED ON THE CLAIM.
0771	1/1/1900	MEMBER HAS MEDICARE MANAGED CARE FOR THE DATE(S) OF SERVICE. THE SERVICE BILLED IS ONLY COVERED IF PROVIDED BY THAT PLAN.
0776	1/1/1900	THE PROVIDER IS NOT LISTED AS THE MEMBER'S NURSING HOME LEVEL OF CARE PROVIDERFOR THESE DATES OF SERVICE.
0780	1/1/1900	HAC NEVER EVENT MOD PRESENT
0784	1/1/1900	DENIED/CUTBACK. ONLY ONE INITIAL VISIT OF EACH DISCIPLINE (NURSING) IS ALLOWEDPER DAY PER MEMBER.
0789	1/1/1900	DENTAL SERVICE LIMITED TO TWICE IN A SIX MONTH PERIOD.
0790	1/1/1900	BILLING PROVIDER MAY ONLY BILL EYEGLASS SERVICES
0794	1/1/1900	PROCEDURE NOT ALLOWED FOR THE CLIA CERTIFICATION TYPE.
0795	1/1/1900	COMPLEX EVALUATION AND MANAGEMENT PROCEDURES REQUIRE HISTORY AND PHYSICAL OR MEDICAL PROGRESS REPORT TO BE SUBMITTED WITH THE CLAIM.
0798	1/1/1900	TPL-PAYMENT IS LESS THAN PERCENTAGE SPECIFIED ON SYSTEM PARAMETER
0801	1/1/1900	ONE OR MORE DIAGNOSIS CODES ARE NOT APPLICABLE TO THE MEMBER'S GENDER.
0806	1/1/1900	EXTERNAL CAUSE OF MORBIDITY DIAGNOSIS CODE(S) ARE INVALID AS THE ADMITTING/PRINCIPAL DIAGNOSIS 1.
0807	1/1/1900	DIAGNOSIS CODE INDICATED IS NOT VALID AS A PRIMARY DIAGNOSIS.
0808	1/1/1900	SECONDARY DIAGNOSIS CODE(S) IN POSITIONS 2-9 CANNOT DUPLICATE THE PRIMARY DISCHARGE DIAGNOSIS.
0809	1/1/1900	THIS CLAIM MUST CONTAIN AT LEAST ONE SPECIFIED ICD PROCEDURE CODE. A CLAIM CANNOT CONTAIN ONLY NOT OTHERWISE SPECIFIED (NOS) ICD PROCEDURE CODES.
0810	1/1/1900	A COVERED DRG CANNOT BE ASSIGNED TO THE CLAIM. THE INFORMATION ON THE CLAIM ISINVALID OR NOT SPECIFIC ENOUGH TO ASSIGN A DRG.
0811	1/1/1900	RELATIVE WEIGHT NOT ON FILE.
0812	1/1/1900	DENIED/CUTBACK. REIMBURSEMENT LIMIT FOR ALL ADJUNCTIVE EMERGENCY SERVICES IS EXCEEDED.
0813	1/1/1900	CLAIM REIMBURSEMENT HAS BEEN CUTBACK TO REIMBURSEMENT LIMITS FOR SERVICES PERFORMED.
0814	1/1/1900	SERVICE NOT COVERED AS DETERMINED BY A MEDICAL CONSULTANT
0815	1/1/1900	DENIED/CUTBACK. HOME HEALTH VISITS (NURSING AND THERAPY) IN EXCESS OF 30 VISITSPER CALENDAR YEAR PER MEMBER REQUIRE PRIOR AUTHORIZATION.
0816	1/1/1900	DENIED/CUTBACK. THERAPY VISITS IN EXCESS OF ONE PER DAY PER DISCIPLINE PER MEMBER ARE NOT REIMBURSABLE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0819	1/1/1900	DENIED/CUTBACK. LIMITED TO ONCE PER QUADRANT PER DAY.
0824	1/1/1900	PROCEDURE CODE IS NOT COVERED FOR MEMBERS WITH A NURSING HOME AUTHORIZATION ONTHE DATE(S) OF SERVICE.
0825	1/1/1900	CASE PLAN AND/OR ASSESSMENT REIMBURSMENT IS LIMITED TO ONE PER CALENDAR YEAR.CALENDAR YEAR.
0826	1/1/1900	SERVICE IS REIMBURSABLE ONLY ONCE PER CALENDAR MONTH.
0829	1/1/1900	TIMELY FILING DEADLINE EXCEEDED.
0832	1/1/1900	ORTHOSIS ADDITIONS IS LIMITED TO TWO PER ORTHOSIS WITHIN THE TWO YEAR LIFE EXPECTANCY OF THE ITEM WITHOUT PRIOR AUTHORIZATION.
0834	1/1/1900	CRITICAL CARE PERFORMED IN AIR AMBULANCE REQUIRES MEDICAL NECESSITY DOCUMENTATION WITH THE CLAIM. CRITICAL CARE IN NON-AIR AMBULANCE IS NOT COVERED.
0836	1/1/1900	FOR REVENUE CODE 0820, 0821, 0825 OR 0829, HCPCS CODE 90999 OR MODIFIER G1-G6 MUST BE PRESENT.
0839	1/1/1900	HOME CARE ONGOING ASSESSMENTS ARE ALLOWED ONCE EVERY SIXTY DAYS PER MEMBER.NT, BUT AREPAYABLE EVERY FIFTY-FOURTH DAY FOR FLEXIBILITY IN SCHEDULING.
0840	1/1/1900	THE TIMELY FILING DEADLINE WAS EXCEEDED. PLEASE RESUBMIT VIA WEB PORTAL OR PAPER WITH DOCUMENTATION.
0841	1/1/1900	THE TIMELY FILING DEADLINE WAS EXCEEDED.
0842	1/1/1900	REFER TO THE PDL. THE REQUESTED DRUG DOES NOT MEET THE AGE LIMIT. REQUIRES AN AGE WAIVER SIGNED BY THE PRESCRIBER FOR APPROVAL.
0843	1/1/1900	THREE FIELDS REQUIRED FOR DUR OVERRIDE.
0844	1/1/1900	PERSONAL CARE SUBSEQUENT AND/OR FOLLOW UP VISITS LIMITED TO SEVEN PER DATE OF SERVICE PER MEMBER.
0852	1/1/1900	NDC REQUIRES WHOLE NUMBER FOR QTY BILLED
0853	1/1/1900	DISPENSE DATE OF SERVICE IS REQUIRED.
0858	1/1/1900	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	1/1/1900	MODIFIERS SUBMITTED ARE INVALID FOR THE DATE OF SERVICE OR ARE MISSING.
0860	1/1/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE SIXTH DIAGNOSIS CODE.
0861	1/1/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE SEVENTH DIAGNOSISCODE.
0862	1/1/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE EIGHTH DIAGNOSIS CODE.
0863	1/1/1900	A DIAGNOSIS CODE OF GREATER SPECIFICITY MUST BE USED FOR THE NINTH DIAGNOSIS CODE.
0868	1/1/1900	DENIED. ELECTION FORM IS NOT ON FILE FOR THIS MEMBER. RESUBMIT CLAIM ONCE ELECTION FORM REQUIREMENTS ARE MET PER THE HOSPICE PROVIDER HANDBOOK.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0876	1/1/1900	CHILD CARE COORDINATION SERVICES ARE REIMBURSABLE ONLY IF BOTH THE MEMBER AND PROVIDER ARE LOCATED IN MILWAUKEE COUNTY.
0888	1/1/1900	A VALID OTHER PAYER CLAIM FILING INDICATOR IS REQUIRED ON PORTAL CLAIM SUBMISSION.
0901	1/1/1900	THE FROM DATE OF SERVICE AND TO DATE OF SERVICE MUST BE IN THE SAME CALENDAR MONTH AND YEAR.
0904	1/1/1900	Occurrence Code Group Not Found
0918	1/1/1900	MEDICARE DISCLAIMER CODE INVALID. MEMBER IS NOT MEDICARE ENROLLED AND/OR PROVIDER IS NOT MEDICARE CERTIFIED.
0919	1/1/1900	BILLING PROVIDER DOES NOT HAVE REQUIRED CERTIFICATION ADDENDUM ON FILE.
0920	1/1/1900	OTHER COVERAGE CODE IS NOT ALLOWED.
0922	1/1/1900	DUPLICATE COMPOUND INGREDIENT BILLED.
0923	1/1/1900	REIMBURSEMENT FOR THIS PROCEDURE AND A RELATED PROCEDURE IS LIMITED TO ONCE PERDATE OF SERVICE.
0925	1/1/1900	THIS PROCEDURE IS LIMITED TO ONCE PER DAY.
0931	1/1/1900	CONDITION CODE IS MISSING/INVALID OR INCORRECT FOR THE PROCEDURE OR REVENUE CODE SUBMITTED.
0933	1/1/1900	SERVICE IS COVERED ONLY DURING THE FIRST MONTH OF ENROLLMENT IN THE HOME AND COMMUNITY BASED WAIVER.
0935	1/1/1900	INVALID BILLING OF PROCEDURE CODE.
0937	1/1/1900	THIS CLAIM IS BEING DENIED BECAUSE IT IS AN EXACT DUPLICATE OF CLAIM SUBMITTED.
0939	1/1/1900	X12 OR NCPDP VERSION IS INVALID
0940	1/1/1900	DME RENTAL IS LIMITED TO 15 MONTHS WITHOUT PRIOR AUTHORIZATION.
0941	1/1/1900	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	1/1/1900	THIS PROCEDURE CODE IS DENIED AS MUTUALLY EXCLUSIVE TO ANOTHER CODE BILLED ON THIS CLAIM.
0943	1/1/1900	THIS PROCEDURE CODE IS DENIED AS INCIDENTAL/INTEGRAL TO ANOTHER PROCEDURE CODEBILLED ON THIS CLAIM.
0944	1/1/1900	QUANTITY BILLED IS NOT EQUALLY DIVISIBLE BY THE NUMBER OF DATES OF SERVICE ON THE DETAIL.
0945	1/1/1900	SERVICES ON THIS CLAIM HAVE BEEN SPLIT TO FACILITATE PROCESSING.ON ON YOUR PART IS REQUIRED.
0946	1/1/1900	CLAIM REVIEWED BY PHARMACY CONSULTANT
0947	1/1/1900	CLAIM REVIEWED BY DOM PHARMACY CONSULTANT
0948	1/1/1900	CLAIM REVIEWED BY MEDICAL CONSULTANT
0949	1/1/1900	CLAIM REVIEWED BY DOM MEDICAL CONSULTANT
0957	1/1/1900	OTHER PAYER COVERAGE TYPE NOT ALLOWED.
0958	1/1/1900	DENIED. PLEASE RESUBMIT THIS CLAIM WITH THE INSURANCE EOB SHOWING A DENIAL OR PARTIAL PAYMENT.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
0959	1/1/1900	DENIED. THE INSURANCE EOB DOES NOT CORRESPOND TO THE DATES OF SERVICE/SERVICESBEING BILLED.
0961	1/1/1900	SPEECH THERAPY LIMITED TO 35 TREATMENT DAYS PER LIFETIME WITHOUT PRIOR AUTHORIZATION.
0962	1/1/1900	CLAIM INDICATES OTHER INSURANCE COVERAGE BUT THE MEMBER DOES NOT HAVE COMMERCIAL INSURANCE FOR THE DATE(S) OF SERVICE ON FILE
0963	1/1/1900	PHYSICAL THERAPY LIMITED TO 35 TREATMENT DAYS PER LIFETIME WITHOUT PRIOR AUTHORIZATION.
0965	1/1/1900	OCCUPATIONAL THERAPY LIMITED TO 35 TREATMENT DAYS PER LIFETIME WITHOUT PRIOR AUTHORIZATION.
0970	1/1/1900	MORE THAN 50 HOURS OF PERSONAL CARE SERVICES PER CALENDAR YEAR REQUIRE PRIOR AUTHORIZATION.
0974	1/1/1900	DENIED. PROVIDERS MAY ONLY BILL FOR ASSESSMENTS AND CARE PLANS TWICE PER CALENDAR YEAR.
0979	1/1/1900	PHARMACEUTICAL CARE ALLOWED WITH PAYABLE NDC OR IF RX NOT FILLED A QTY OF ZERO.
0987	1/1/1900	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	1/1/1900	CLAIM DENIED. ATTACHMENT WAS NOT RECEIVED WITHIN 21 DAYS OF A CLAIM RECEIPT.
0992	1/1/1900	DENIED/CUTBACK. THE DISPOSABLE MEDICAL SUPPLY PROCEDURE CODE HAS A CONTRACTED MAX QUANTITY LIMIT. PRIOR AUTHORIZATION IS REQUIRED TO EXCEED THIS LIMIT.
0994	1/1/1900	COMPOUND REQUIRES 2 OR MORE INGREDIENTS.
0996	1/1/1900	PHARMACEUTICAL CARE LIMIT EXCEEDED.
0999	1/1/1900	RURAL HEALTH CLINICS MAY ONLY BILL REVENUE CODES ON MEDICARE CROSSOVER CLAIMS
1000	1/1/1900	CLAIM PENDED FOR EXAMINER REVIEW
1001	1/1/1900	COB- BENEFIT PLAN
1002	1/1/1900	COB - PAYER
1003	1/1/1900	SERVICE DENIED BECAUSE SIGNFICANT CONTINOUS STAY SERVICE WAS DENIED.
1004	1/1/1900	MULTIPLE SIGNIFICANT CONTINUOUS STAY SERVICES BILLED ON THE SAME CLAIM AND AT LEAST ONE SIGNIFICANT SERVICE MAY DENY.
1005	1/1/1900	THE ELIGIBILITY OF THE MEMBER DOES NOT FALL WITHIN THE DEPARTMENT OF CORRECTIONRESTRICTION.
1009	1/1/1900	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
1011	1/1/1900	CONTRACT COULD NOT BE DETERMINDED

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1012	1/1/1900	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	1/1/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM PREVIOUSLY SUBMITTED. ADJUST AS NECESSARY.
1015	1/1/1900	PAYMENT HAS BEEN MADE TO ANOTHER PROVIDER FOR THIS SERVICE FOR THE SAME DATE.VERIFY YOUR BILLING, CORRECT AND RESUBMIT, OR RESUBMIT WITH DOCUMENTATION.
1017	1/1/1900	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	1/1/1900	PAYMENT HAS ALREADY BEEN MADE TO THE PERFORMING PROVIDER UNDER A DIFFERENT BILLING PROVIDER NUMBER. REVIEW. IF CORRECT, RESUBMIT WITH DOCUMENTATION FOR BOTHSERVICES.
1020	1/1/1900	ALL OR PART OF THIS CLAIM IS A DUPLICATE OF A CROSSOVER CLAIM WHICH HAS ALREADYBEEN PAID.
1021	1/1/1900	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	1/1/1900	YOU OR ANOTHER PROVIDER HAVE BILLED FOR A COMPREHENSIVE ORAL EXAM WITHIN TWO YEARS. IF CORRECT, RESUBMIT WITH EXPLANATION.
1023	1/1/1900	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	1/1/1900	RESTORATIONS FOR SAME TOOTH AND SURFACE/S ARE COVERED ONE TIME IN TWO YEARS. RESUBMIT WITH DOCUMENTATION AND NARRATIVE.
1025	1/1/1900	PROCEDURE CODE BILLED REQUIRES AN ARCH.
1026	1/1/1900	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	1/1/1900	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	1/1/1900	EXPECTED HEADSTART ENROLLMENT DATE REQUIRED IN ORDER TO CONSIDER INTERPERIODICEVALUATION.
1029	1/1/1900	SERVICE COVERED ONE TIME IN TWO YEARS. YOU OR ANOTHER PROVIDER HAVE BEEN REIMBURSED FOR THIS SERVICE.
1030	1/1/1900	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	1/1/1900	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.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1032	1/1/1900	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	1/1/1900	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	1/1/1900	ANOTHER PROVIDER HAS BILLED FOR THIS SERVICE IN THE LAST 6 MONTHS. RESEND WITHDOCUMENTATION AND NARRATIVE FOR DEFECTIVE RESTORATION.
1035	1/1/1900	RESUBMIT WITH CARIES RISK ASSESSMENT CODE FOR REIMBURSMENT.
1036	1/1/1900	PROCEDURE IS ALLOWED ONE TIME IN 6 MONTHS AFTER COMPLETION OF PERIODONTAL SCALING. MUST NOT BE BILLED WITHIN 3 MONTHS OF PROPHYLAXIS.
1037	1/1/1900	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	1/1/1900	RESUBMIT WITH ACTUAL TEST RESULTS TO DOCUMENT THE LABORATORY SERVICE BILLED.
1039	1/1/1900	YOU ARE BILLING FOR MULTIPLE SURGICAL PROCEDURES ON THE SAME DAY. AN OPERATIVEREPORT IS REQUIRED IN ORDER TO DETERMINE THE PROPER PAYMENT.
1040	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	MEDICARE COINSURANCE OR PAYMENT IS NOT WITHIN AN ALLOWABLE RANGE.
1052	1/1/1900	YOU HAVE ALREADY BEEN PAID FOR THE EXTRACTION OF THIS TOOTH FOR ANOTHER DATE OFSERVICE
1053	1/1/1900	ONE NEW PATIENT SERVICE PER 3 YEARS PER PROVIDER
1056	1/1/1900	THIS PROCEDURE REQUIRES BILLING EACH DATE OF SERVICE ON A SEPARATE DETAIL WITHTHE ASSOCIATED NUMBER OF UNITS FOR THAT DAY.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1057	1/1/1900	PLEASE RESUBMIT WITH DOCUMENTATION FROM OFFICE, OUTPATIENT, OR HOSPITAL SERVICEBEING BILLED.
1058	1/1/1900	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	1/1/1900	YOU ARE BILLING A HOSPITAL READMISSION WITHIN 10 DAYS OF INITIAL DISCHARGE. RESUBMIT WITH DISCHARGE SUMMARY FOR BOTH ADMISSIONS.
1060	1/1/1900	YOU ARE BILLING A HOSPITAL READMISSION WITHIN 10 DAYS OF INITIAL DISCHARGE. BASED ON REVIEW OF DOCUMENTATION SUBMITTED, THIS CLAIM WILL NOT BE PAID.
1061	1/1/1900	DOCUMENTATION DOES NOT SUPPORT REIMBURSMENT FOR ADDITIONAL RESTORATION.
1062	1/1/1900	PHOTOGRAPHS ARE ONLY ALLOWED ONE TIME IN 6 MONTHS WHEN REQUESTED FOR DENTAL REVIEW.
1063	1/1/1900	PHOTOGRAPHS ARE ONLY ALLOWED TO BE BILLED FOR INTERCEPTIVE OR LIMITED ORTHODONTICS ONE TIME.
1064	1/1/1900	MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS ARE ZERO
1065	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	RESUBMIT WITH THE PHYSICIAN'S ORDER AND THE REPORT OF LAB RESULTS TO JUSTIFY SERVICES AS BILLED.
1071	1/1/1900	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	1/1/1900	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	1/1/1900	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.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1075	1/1/1900	YOU ARE BILLING MORE THAN 7 DAYS OF LEAVE OF ABSENCE IN ONE CALENDAR MONTH. CALL HPES PROVIDER SERVICES WITH QUESTIONS.
1076	1/1/1900	PROV CONTRACT NOT VALID ON DOS - DTL
1077	1/1/1900	RENDERING PROVIDER TAXONOMY NOT VALID FOR PROCEDURE CODE
1078	1/1/1900	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	1/1/1900	THE PROCEDURE ON THE CLAIM APPEARS TO BE A REQUIRED FOR PALLIATIVE TREATMENT.
1080	1/1/1900	PALLIATIVE TREATMENT BILLED ON SAME DAY, FOR THE SAME TOOTH, BY THE SAME PROVIDER, WITH PROCEDURE FOR ROOT CANAL NOT ALLOWED.
1081	1/1/1900	THE HCPCS PROCEDURE CODE BILLED IS INCLUDED IN THE DESCRIPTION OF THE PRIMARY PROCEDURE.
1082	1/1/1900	THIS SERVICE IS NOT PAYABLE WITH ANOTHER SERVICE ON THE SAME DATE OF SERVICE DUE TO NATIONAL CORRECT CODING INITIATIVE.
1083	1/1/1900	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	1/1/1900	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	1/1/1900	PROVIDER IS A FACILITY OR GROUP PROVIDER. A RENDERING PROVIDER IS REQUIRED.
1086	1/1/1900	FORCE DENY-USER
1087	1/1/1900	SERVICES NOT COVERED FOR TOOTH THAT HAS PREVIOUSLY BEEN EXTRACTED
1088	1/1/1900	SERVICE LIMITED TO ONE PER DAY
1089	1/1/1900	SERVICE LIMITED TO ONE EVERY 160 DAYS
1090	1/1/1900	SERVICE LIMITED TO ONE PER DAY PER RENDERING PROVIDER
1091	1/1/1900	SERVICE LIMITED TO ONE PER DAY, PER RENDERING PROVIDER PER TOOTH
1092	1/1/1900	SERVICE LIMITED TO ONE PER DAY, PER PROVIDER PER TOOTH
1093	1/1/1900	SERVICE LIMITED TO ONE EVERY 345 DAYS, PER PROVIDER
1094	1/1/1900	SERVICE LIMITED TO ONE EVERY 5 YEARS, PER PROVDER, PER TOOTH
1095	1/1/1900	SERVICE LIMITED TO ONE PER LIFETIME, PER TOOTH
1096	1/1/1900	SERVICE LIMITED TO ONE PER LIFETIME, PER TOOTH
1097	1/1/1900	MEMBER HAS EXCEEDED $1000 SERVICE LIMIT
1098	1/1/1900	SERVICE LIMITED TO ONE EVERY 10 DAYS
1099	1/1/1900	One LTC Speech Therapy eval per year
1100	1/1/1900	THE AMOUNT IN THE OTHER INSURANCE FIELD IS INVALID.
1101	1/1/1900	QUANTITY BILLED IS INVALID.
1102	1/1/1900	THE ADMIT DATE IS INVALID.
1103	1/1/1900	THE NUMBER OF COVERED DAYS IS REQUIRED.
1104	1/1/1900	A NUMBER IS REQUIRED IN THE COVERED DAYS FIELD.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1105	1/1/1900	ONE OR MORE OCCURRENCE CODE DATE(S) IS INVALID IN POSITIONS NINE THROUGH 24.
1106	1/1/1900	INTERIM BILLING CRITERIA NOT MET.
1107	1/1/1900	ADMIT DATE AND FROM DATE OF SERVICE MUST MATCH.
1108	1/1/1900	GROSS AMOUNT DUE AND/OR U&C REQUIRED.
1109	1/1/1900	RENDERING PROVIDER IS NOT A CERTIFIED PROVIDER.
1112	1/1/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE RENDERING PROVIDER LISTED IN THE HEADER.
1113	1/1/1900	SERVICES ARE NOT PAYABLE. MEMBER IS ON REVIEW.
1116	1/1/1900	THE REVENUE CODE REQUIRES AN APPROPRIATE CORRESPONDING PROCEDURE CODE.
1117	1/1/1900	THE NATIONAL DRUG CODE (NDC) HAS AN AGE RESTRICTION.
1118	1/1/1900	THE NATIONAL DRUG CODE (NDC) HAS A QUANTITY RESTRICTION.
1119	1/1/1900	ONE OR MORE DIAGNOSIS CODES HAS AN AGE RESTRICTION.
1120	1/1/1900	ONE OR MORE DIAGNOSIS CODES HAS A GENDER RESTRICTION.
1121	1/1/1900	MEMBER DOES NOT MEET THE AGE RESTRICTION FOR THIS PROCEDURE CODE.
1122	1/1/1900	FAMILY PLANNING FUNDING 90% .
1123	1/1/1900	FAMILY PLANNING FUNDING REGULAR MATCH
1124	1/1/1900	FAMILY PLANNING FUNDING ERROR
1125	1/1/1900	NO FEDERAL DRUG REBATE AGREEMENT.
1126	1/1/1900	SECOND MODIFIER CODE IS INVALID FOR DATE OF SERVICE.
1127	1/1/1900	THIRD MODIFIER CODE IS INVALID FOR DATE OF SERVICE.
1128	1/1/1900	A TOOTH NUMBER OR LETTER IS REQUIRED.
1129	1/1/1900	OCCURRENCE CODE IS REQUIRED WHEN AN OCCURRENCE DATE IS PRESENT.
1130	1/1/1900	ONE OR MORE CONDITION CODE(S) IS INVALID IN POSITIONS EIGHT THROUGH 24.
1131	1/1/1900	THE PRIMARY OCCURRENCE CODE IS INVALID.
1132	1/1/1900	A PRIMARY OCCURRENCE CODE DATE IS REQUIRED.
1133	1/1/1900	PRINCIPAL SURGICAL CODE DATE IS INVALID.
1134	1/1/1900	FIRST OCCURRENCE SPAN CODE IS INVALID.
1135	1/1/1900	ONE OR MORE FROM DATE(S) OF SERVICE IS INVALID FOR OCCURRENCE SPAN CODES IN POSITIONS THREE THROUGH 24.
1136	1/1/1900	THE AREA OF THE ORAL CAVITY IS INVALID.
1137	1/1/1900	VALUE CODE IS INVALID.
1138	1/1/1900	VALUE CODE AMOUNT IS INVALID.
1139	1/1/1900	HEADER FROM DATE OF SERVICE IS AFTER THE DATE OF RECEIPT OF THE CLAIM.
1140	1/1/1900	NO WCDP DRUG REBATE AGREEMENT.
1141	1/1/1900	MEMBER ENROLLED IN MEDICARE PART D. PDP PAYMENT/DENIAL REQUIRED ON CLAIM.
1142	1/1/1900	THIS MODIFIER HAS BEEN DISCONTINUED BY CMS OR AMA FOR THE DATE OF SERVICE(S).
1143	1/1/1900	ACCOMMODATION CODE(S) IS NOT PAYABLE.
1144	1/1/1900	CMS TERMINATED DRUG.
1145	1/1/1900	AREA OF THE ORAL CAVITY IS REQUIRED FOR PROCEDURE CODE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1146	1/1/1900	THE SECOND OTHER PROVIDER ID IS MISSING OR INVALID.
1147	1/1/1900	ADMIT DIAGNOSIS CODE IS INVALID.
1148	1/1/1900	SECOND DIAGNOSIS CODE IS INVALID.
1149	1/1/1900	THIRD DIAGNOSIS CODE IS INVALID.
1150	1/1/1900	FOURTH DIAGNOSIS CODE IS INVALID.
1151	1/1/1900	THE FIFTH DIAGNOSIS CODE IS INVALID.
1152	1/1/1900	THE SIXTH DIAGNOSIS CODE IS INVALID.
1153	1/1/1900	THE SEVENTH DIAGNOSIS CODE IS INVALID.
1154	1/1/1900	THE EIGHTH DIAGNOSIS CODE IS INVALID.
1155	1/1/1900	THE NINTH DIAGNOSIS CODE IS INVALID.
1156	1/1/1900	PRIMARY DIAGNOSIS CODE IS INVALID.
1157	1/1/1900	ONE OR MORE DIAGNOSIS CODE(S) IS INVALID IN POSITIONS 10 THROUGH 25.
1158	1/1/1900	PRIMARY DIAGNOSIS CODE IS REQUIRED.
1159	1/1/1900	ONE OR MORE DIAGNOSIS CODE(S) IS INVALID FOR THE DATE(S) OF SERVICE.
1160	1/1/1900	PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
1161	1/1/1900	SECONDARY DIAGNOSIS CODE IS NOT ON FILE.
1162	1/1/1900	THIRD DIAGNOSIS CODE IS NOT ON FILE.
1163	1/1/1900	FOURTH DIAGNOSIS CODE IS NOT ON FILE.
1164	1/1/1900	FIFTH DIAGNOSIS CODE IS NOT ON FILE.
1165	1/1/1900	SIXTH DIAGNOSIS CODE IS NOT ON FILE.
1166	1/1/1900	SEVENTH DIAGNOSIS CODE IS NOT ON FILE.
1167	1/1/1900	EIGHTH DIAGNOSIS CODE IS NOT ON FILE.
1168	1/1/1900	NINTH DIAGNOSIS CODE IS NOT ON FILE.
1169	1/1/1900	ONE OR MORE DIAGNOSIS CODE(S) IN POSITIONS 10 THROUGH 25 IS NOT ON FILE.
1170	1/1/1900	TENTH DIAGNOSIS IS INVALID.
1171	1/1/1900	ELEVENTH DIAGNOSIS IS INVALID.
1172	1/1/1900	TWELFTH DIAGNOSIS IS INVALID
1173	1/1/1900	TENTH DIAGNOSIS IS NOT ON FILE.
1174	1/1/1900	THE PROCEDURE CODE IS NOT REIMBURSABLE FOR A FAMILY PLANNING WAIVER MEMBER.
1175	1/1/1900	THE PATIENT STATUS CODE IS INVALID OR CONFLICTS WITH TYPE OF BILL (TOB).
1177	1/1/1900	PATIENT LOCATION IS INVALID.
1178	1/1/1900	SERVICE IS NOT REIMBURSABLE FOR DATE(S) OF SERVICE.
1179	1/1/1900	VALID QUANTITY BILLED IS REQUIRED.
1180	1/1/1900	RX DATE AFTER DISPENSE DATE OF SERVICE.
1181	1/1/1900	PRESCRIPTION DATE EXCEEDS ONE YEAR.
1183	1/1/1900	HEADER FROM DATE OF SERVICE IS AFTER THE HEADER TO DATE OF SERVICE.
1184	1/1/1900	THE HEADER AND DETAIL DATE(S) OF SERVICE CONFLICT.
1185	1/1/1900	THE PROCEDURECODE IS NOT COVERED FOR THE DATE(S) OF SERVICE.
1186	1/1/1900	THE PROCEDURE CODE IS NOT COVERED FOR THE REVENUE CODE BILLED FOR THE DATE(S) OF SERVICE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1187	1/1/1900	THE REVENUE CODE IS NOT PAYABLE FOR THE DATE(S) OF SERVICE.
1190	1/1/1900	ONE OR MORE DIAGNOSIS CODE(S) IS NOT PAYABLE FOR THE DATE OF SERVICE.
1193	1/1/1900	DISPENSE DATE AFTER CLAIM RECEIPT DATE.
1194	1/1/1900	BILLED AMOUNT IS NOT EQUALLY DIVISIBLE BY THE NUMBER OF DATES OF SERVICE ON THEDETAIL.
1197	1/1/1900	THE PROCEDURE CODE HAS PLACE OF SERVICE RESTRICTIONS.
1198	1/1/1900	A NATIONAL DRUG CODE (NDC) IS REQUIRED FOR THIS HCPCS CODE.
1199	1/1/1900	ONE OR MORE OF THE NDCS SUBMITTED IS NOT RELATED TO THE PROCEDURE CODE BILLED.
1200	1/1/1900	THE NATIONAL DRUG CODE (NDC) SUBMITTED WITH THIS HCPCS CODE IS CMS TERMINATED.
1201	1/1/1900	INVALID QUANTITY FOR THE NATIONAL DRUG CODE (NDC) SUBMITTED WITH THIS HCPCS CODE.
1202	1/1/1900	PRESCRIBER ID IS REQUIRED.
1203	1/1/1900	OUT OF STATE PROVIDER NOT CERTIFIED.
1204	1/1/1900	BILLING PROVIDER IS NOT CERTIFIED FOR THE DATE(S) OF SERVICE.
1205	1/1/1900	OUT OF STATE BILLING PROVIDER NOT ENROLLED FOR ENTIRE DETAIL DOS SPAN.
1207	1/1/1900	A NATIONAL PROVIDER IDENTIFIER (NPI) IS REQUIRED FOR THE BILLING PROVIDER.
1210	1/1/1900	PCN REQUIRED FOR SENIORCARE/WCDP/ADAP.
1211	1/1/1900	THE SURGICAL PROCEDURE CODE HAS DIAGNOSIS RESTRICTIONS.
1212	1/1/1900	NDC HAS ENCOUNTER INDICATOR RESTRICTIONS
1213	1/1/1900	THE PROCEDURE CODE HAS ENCOUNTER INDICATOR RESTRICTIONS.
1214	1/1/1900	THIS REVENUE CODE HAS ENCOUNTER INDICATOR RESTRICTIONS.
1215	1/1/1900	THIS DIAGNOSIS CODE HAS ENCOUNTER INDICATOR RESTRICTIONS.
1216	1/1/1900	THIS SURGICAL CODE HAS ENCOUNTER INDICATOR RESTRICTIONS.
1218	1/1/1900	THE PROCEDURE CODE IS RESTRICTED.
1219	1/1/1900	REVENUE ENCOUNTER BILLING RULE EDIT.
1221	1/1/1900	DIAGNOSIS RESTRICTION ON ICD PROCEDURE COVERAGE RULE.
1222	1/1/1900	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	1/1/1900	PROSPECTIVE DUR ALERT
1225	1/1/1900	DRUG FOR LTC ONLY *NOTE DAY 2- N/A AT THIS TIME
1227	1/1/1900	THE OTHER PAYER ID QUALIFIER IS INVALID.
1228	1/1/1900	THE OTHER PAYER AMOUNT PAID QUALIFIER IS INVALID.
1229	1/1/1900	COMPOUND DRUGS NOT COVERED FOR PROGRAM.
1230	1/1/1900	THE MEDICARE COPAYMENT AMOUNT IS INVALID.
1231	1/1/1900	PRINCIPLE SURGICAL PROCEDURE CODE DATE IS MISSING.
1232	1/1/1900	NON-PREFERRED DRUG IS BEING DISPENSED. PLEASE REFER TO THE PDL FOR PREFERRED DRUGS IN THIS THERAPEUTIC CLASS.
1233	1/1/1900	SUBMISSION CLARIFICATION CODE INVALID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1234	1/1/1900	NDC NOT COVERED.
1237	1/1/1900	THE BILLING PROVIDER'S TAXONOMY CODE IS INVALID.
1238	1/1/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IN THE HEADER IS INVALID.
1239	1/1/1900	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	1/1/1900	COVERAGE LIMITED TO PREFERRED DRUGS.
1242	1/1/1900	COVERAGE LIMITED TO GENERIC DRUGS.
1243	1/1/1900	COVERAGE LIMITED TO NON-INNOVATOR DRUGS.
1244	1/1/1900	ELEVENTH DIAGNOSIS IS NOT ON FILE.
1245	1/1/1900	TWELFTH DIAGNOSIS IS NOT ON FILE.
1246	1/1/1900	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1247	1/1/1900	NOT USED - DMAP OR THE MEMBER CANNOT BE CHARGED SALES TAX.
1248	1/1/1900	TOTAL OTHER PAYER COSTSHARE FOR MEMBER IS REQUIRED.
1249	1/1/1900	ADDITIONAL COSTS ARE NOT COVERED.
1250	1/1/1900	VALID PLACE OF SERVICE IS REQUIRED.
1254	1/1/1900	DME RENTAL BEYOND THE INITIAL 60 DAY PERIOD IS NOT PAYABLE WITHOUT PRIOR AUTHORIZATION.
1255	1/1/1900	DME RENTAL BEYOND THE INITIAL 180 DAY PERIOD IS NOT PAYABLE WITHOUT PRIOR AUTHORIZATION.
1256	1/1/1900	MEMBER IS ENROLLED IN MEDICARE PART A ON THE DATE(S) OF SERVICE.
1257	1/1/1900	MEMBER IS ENROLLED IN MEDICARE PART B ON THE DATE(S) OF SERVICE.
1258	1/1/1900	SERVICE(S) PAID IN ACCORDANCE WITH PROGRAM POLICY LIMITATION.
1259	1/1/1900	HEADER BILLING PROVIDER IS NO LONGER ENROLLED FOR THE DATE OF SERVICE
1260	1/1/1900	THE SUM OF THE ACCOMMODATION DAYS IS NOT EQUAL TO THE HEADER DATE SPAN.
1261	1/1/1900	DETAIL TO DATE OF SERVICE IS INVALID.
1262	1/1/1900	DETAIL TO DATE OF SERVICE IS REQUIRED.
1263	1/1/1900	HEADER AND/OR DETAIL DATES OF SERVICE ARE MISSING, INCORRECT OR CONTAIN FUTUREDATES.
1264	1/1/1900	ADMIT DIAGNOSIS IS REQUIRED.
1265	1/1/1900	THE ADMIT TYPE CODE IS REQUIRED.
1266	1/1/1900	PATIENT STATUS CODE IS INCORRECT FOR LONG TERM CARE CLAIMS.
1267	1/1/1900	THE PATIENT STATUS CODE IS REQUIRED.
1268	1/1/1900	MEDICARE PAID, COINSURANCE, COPAYMENT AND/OR DEDUCTIBLE AMOUNTS DO NOT BALANCE.
1269	1/1/1900	THE SUM OF THE MEDICARE PAID, DEDUCTIBLE(S), COINSURANCE, COPAYMENT AND PSYCHIATRIC REDUCTION AMOUNTS DOES NOT EQUAL THE MEDICARE ALLOWED AMOUNT.
1270	1/1/1900	THE HEADER TOTAL BILLED AMOUNT IS REQUIRED AND MUST BE GREATER THAN ZERO.
1271	1/1/1900	THE TOTAL BILLED AMOUNT IS MISSING OR INCORRECT.
1272	1/1/1900	SUM OF DETAIL BILLED AMOUNTS EXCEED TOTAL BILLED AMOUNT.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1273	1/1/1900	QUANTITY BILLED IS INVALID FOR THE REVENUE CODE.
1275	1/1/1900	QUANTITY BILLED IS RESTRICTED FOR THIS PROCEDURE CODE.
1276	1/1/1900	CLAIM OR ADJUSTMENT RECEIVED BEYOND 730-DAY FILING DEADLINE.
1277	1/1/1900	MEMBER IS NOT ENROLLED FOR THE DISPENSE DATE OF SERVICE.
1278	1/1/1900	PLACE OF SERVICE CODE IS INVALID.
1279	1/1/1900	PROCEDURE NOT PAYABLE FOR PLACE OF SERVICE.
1280	1/1/1900	RENDERING PROVIDER TYPE AND/OR SPECIALTY IS NOT ALLOWABLE FOR THE SERVICE BILLED.
1281	1/1/1900	SURGICAL PROCEDURE CODE BILLED IS NOT APPROPRIATE FOR MEMBER'S GENDER.
1282	1/1/1900	PA REQUIRED FOR PAYMENT OF THIS SERVICE. PROCEDURE CODE AND MODIFIERS BILLED MUST MATCH APPROVED PA.
1283	1/1/1900	PRIOR AUTHORIZATION (PA) REQUIRED FOR PAYMENT OF THIS SERVICE.
1284	1/1/1900	RENDERING PROVIDER IS NOT CERTIFIED FOR THE FROM DATE OF SERVICE.
1285	1/1/1900	THE PRESCRIBER ID IS INVALID.
1286	1/1/1900	DAYS SUPPLY MISSING OR GREATER THAN ALLOWED.
1287	1/1/1900	QUANTITY DISPENSED IS REQUIRED.
1288	1/1/1900	SUBMITTED RENDERING PROVIDER NPI IN THE HEADER IS INVALID.
1289	1/1/1900	TYPE OF BILL INDICATES SERVICES NOT REIMBURSABLE OR FREQUENCY INDICATED IS NOTVALID FOR THE CLAIM TYPE.
1290	1/1/1900	TYPE OF BILL IS INVALID FOR THE CLAIM TYPE.
1291	1/1/1900	VALID SOURCE OF ADMISSION IS REQUIRED.
1293	1/1/1900	IF PRESCRIPTION NUMBER IS MISSING (ZEROS) OR NOT NUMERIC - THEN POST THE ERROR.
1294	1/1/1900	HEADER BILL DATE IS BEFORE THE HEADER FROM DATE OF SERVICE.
1295	1/1/1900	THIS NDC IS INVALID.
1296	1/1/1900	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	1/1/1900	MEMBER ENROLLED IN COMMERCIAL HEALTH INSURANCE ON DISPENSE DATE.
1298	1/1/1900	MEMBER ID IS NOT ON FILE. BILL USING THE FIRST 9 DIGITS ON THE ID CARD AND NO LEADING ZEROS.
1301	1/1/1900	THIS PROCEDURE IS DUPLICATIVE OF A SERVICE ALREADY BILLED FOR SAME DATE OF SERVICE.
1302	1/1/1900	THIS SERVICE IS DUPLICATIVE OF SERVICE PROVIDED BY ANOTHER PROVIDER FOR THE SAME DATE(S) OF SERVICE.
1303	1/1/1900	PROGRAM GUIDELINES OR COVERAGE WERE EXCEEDED.
1304	1/1/1900	THE DENTAL PROCEDURE CODE AND TOOTH NUMBER COMBINATION IS ALLOWED ONLY ONCE PERLIFETIME.
1305	1/1/1900	THE DENTAL PROCEDURE CODE AND TOOTH NUMBER COMBINATION IS ALLOWED ONLY ONCE PERLIFETIME.
1306	1/1/1900	ADD-ON CODES ARE NOT SEPARATELY REIMBURSEABLE WHEN SUBMITTED AS A STAND-ALONE CODE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1307	1/1/1900	ENHANCED PAYMENT FOR PROVIDING SERVICES IN A NATURAL ENVIRONMENT IS LIMITED TOONE SERVICE PER DISCIPLINE PER DAY.
1309	1/1/1900	DRUG HAS BEEN PAID UNDER EQUIVALENT CODE WITHIN SEVEN DAYS OF THIS DOS.
1313	1/1/1900	PHARMACEUTICAL CARE NOT COVERED.
1315	1/1/1900	PATIENT REASON FOR VISIT IS INVALID.
1316	1/1/1900	EXTERNAL CAUSE OF INJURY IS INVALID.
1317	1/1/1900	A REVENUE CODE IS REQUIRED.
1318	1/1/1900	FIFTH OTHER SURGICAL CODE IS INVALID.
1319	1/1/1900	FIRST OTHER SURGICAL CODE IS INVALID.
1320	1/1/1900	FOURTH OTHER SURGICAL CODE IS INVALID.
1321	1/1/1900	INCORRECT OR INVALID NDC/PROCEDURE CODE/REVENUE CODE BILLED FOR DATE OF SERVICE.
1322	1/1/1900	INCORRECT OR INVALID NDC/PROCEDURE CODE/REVENUE CODE BILLED.
1323	1/1/1900	ONE OR MORE OTHER PROCEDURE CODES IN POSITION SIX THROUGH 24 ARE INVALID.
1324	1/1/1900	ONE OR MORE ICD PROCEDURE CODES HAS A GENDER RESTRICTION.
1325	1/1/1900	OTHER PROCEDURE CODE IS INVALID.
1326	1/1/1900	PRINCIPAL PROCEDURE CODE IS INVALID.
1327	1/1/1900	PRINCIPAL SURGICAL CODE IS INVALID.
1328	1/1/1900	PROCEDURE CODE IS INVALID.
1329	1/1/1900	THE REVENUE CODE IS INVALID.
1330	1/1/1900	SECOND OTHER SURGICAL CODE IS INVALID.
1331	1/1/1900	REVENUE CODE IS INVALID.
1332	1/1/1900	THE REVENUE CODE IS NOT REIMBURSABLE FOR THE DATE OF SERVICE.
1333	1/1/1900	THIRD OTHER SURGICAL CODE IS INVALID.
1334	1/1/1900	HEADER FROM DATE OF SERVICE IS INVALID.
1335	1/1/1900	HEADER TO DATE OF SERVICE IS INVALID.
1336	1/1/1900	HEADER TO DATE OF SERVICE IS REQUIRED.
1337	1/1/1900	BRAND MEDICALLY NECESSARY NDC REQUIRE PA
1339	1/1/1900	THE DIAGNOSIS CODE AND/OR PROCEDURE CODE AND/OR PLACE OF SERVICE IS NOT REIMBURSABLE FOR TEMPORARILY ENROLLED PREGNANT WOMEN.
1340	1/1/1900	REIMBURSEMENT RATE IS NOT ON FILE FOR MEMBER'S LEVEL OF CARE.
1341	1/1/1900	PROVIDER ID MISSING/UNIDENTIFIABLE.
1342	1/1/1900	DOSINGS FOR NARCOTIC TREATMENT SERVICE PROGRAM ARE LIMITED TO SIX PER SUNDAY THRU SATURDAY CALENDAR WEEK.
1343	1/1/1900	THE NARCOTIC TREATMENT SERVICE PROGRAM LIMITATIONS HAVE BEEN EXCEEDED. REFER TOTHE ONINE HANDBOOK.
1344	1/1/1900	PRESCRIBING PROVIDER NUMBER NOT FOUND.
1345	1/1/1900	SUBMITTED REFERRING PROVIDER NPI IN THE HEADER IS INVALID.
1346	1/1/1900	BILLING PROVIDER IS NOT CERTIFIED FOR THE DISPENSE DATE OF SERVICE.
1347	1/1/1900	BILLING PROVIDER NUMBER IS NOT FOUND OR NOT VALID FOR DATES OF SERVICE.
1348	1/1/1900	PROVIDER NOT ALLOWED TO BILL THIS NDC.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1349	1/1/1900	LTC ACCOMODATION CODE QUANTITY BILLED MUST BE EQUAL TO DETAIL DATE RANGE.
1350	1/1/1900	PRESCRIBER ID QUALIFIER MUST BE 01.
1351	1/1/1900	GENDER RESTRICTION FOR NDC.
1353	1/1/1900	NATIONAL DRUG CODE (NDC) IS INVALID.
1354	1/1/1900	NATIONAL DRUG CODE (NDC) IS NOT ON FILE.
1355	1/1/1900	NATIONAL DRUG CODE (NDC) IS REQUIRED.
1356	1/1/1900	NDC INVALID FOR DISPENSE DATE OF SERVICE
1357	1/1/1900	NDC NOT COVERED FOR CLAIM TYPE.
1358	1/1/1900	NDC RESTRICTED BY MEMBER AGE.
1359	1/1/1900	MEMBER IS ENROLLED IN QMB-ONLY BENEFITS. ONLY MEDICARE CROSSOVER CLAIMS ARE REIMBURSABLE.
1360	1/1/1900	NOT USED - RENDERING PROVIDER IS NOT A CERTIFIED PROVIDER FOR DMAP.
1361	1/1/1900	RENDERING PROVIDER IS NOT A CERTIFIED PROVIDER FOR DELAWARE CANCER TREATMENT PROGRAM.
1362	1/1/1900	DAW NOT ALLOWED FOR NDC.
1363	1/1/1900	THE NATIONAL DRUG CODE (NDC) IS NOT ON FILE FOR THE DISPENSE DATE OF SERVICE.
1364	1/1/1900	THE NATIONAL DRUG CODE (NDC) IS NOT PAYABLE FOR THE PROVIDER TYPE AND/OR SPECIALTY.
1365	1/1/1900	NDC NOT COVERED FOR DATE OF SERVICE.
1366	1/1/1900	NDC NOT COVERED BY FAMILY PLANNING ONLY SERVICES.
1367	1/1/1900	NDC HAS DIAGNOSIS RESTRICTIONS.
1369	1/1/1900	PHARMACUETICAL CARE LIMITATION EXCEEDED.
1370	1/1/1900	MEMBER IS ASSIGNED TO A HOSPICE PROVIDER. ALL SERVICES SHOULD BE COORDINATED WITH THE HOSPICE PROVIDER.
1371	1/1/1900	MEMBER IS ASSIGNED TO A LOCK-IN PRIMARY PROVIDER. ALL SERVICES SHOULD BE COORDINATED WITH THE PRIMARY PROVIDER.
1372	1/1/1900	MEMBER IS ASSIGNED TO AN INPATIENT HOSPITAL PROVIDER. ALL SERVICES SHOULD BE COORDINATED WITH THE INPATIENT HOSPITAL PROVIDER.
1374	1/1/1900	A DIAGNOSIS OF GREATER SPECIFICITY MUST BE USED FOR THE DIAGNOSIS CODE IN POSITIONS 10 THROUGH 24.
1375	1/1/1900	SUBMITTED RENDERING PROVIDER NPI IN THE DETAIL IS INVALID.
1376	1/1/1900	SUBMITTED REFERRING PROVIDER NPI IN THE DETAIL IS INVALID.
1377	1/1/1900	THE PROCEDURE CODE HAS DIAGNOSIS RESTRICTIONS.
1378	1/1/1900	THE REVENUE CODE IS NOT PAYABLE FOR MEMBER'S BENEFIT PLAN.
1379	1/1/1900	THE SERVICES ARE NOT ALLOWED ON THE CLAIM TYPE FOR THE MEMBER'S BENEFIT PLAN.
1380	1/1/1900	THE SURGICAL PROCEDURE CODE IS NOT COVERED FOR THE DATE(S)OF SERVICE.
1381	1/1/1900	THE SURGICAL PROCEDURE CODE IS NOT PAYABLE FOR DELEWARE CANCER TREATMENT PROGRAM FOR THE DATE OF SERVICE.
1382	1/1/1900	ONE OR MORE DIAGNOSIS CODE(S) IS NOT PAYABLE FOR THE DATE OF SERVICE.
1383	1/1/1900	THE FIRST OCCURRENCE SPAN FROM DATE OF SERVICE IS AFTER THE TO DATE OF SERVICE.

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EOB Code	Effective Date	Description
1384	1/1/1900	THE SECOND OCCURRENCE SPAN FROM DATE OF SERVICE IS AFTER TO TO DATE OF SERVICE.
1385	1/1/1900	DISPENSE DATE OF SERVICE IS INVALID.
1386	1/1/1900	BILLING PROVIDER REQUIRED TO BE MEDICARE CERTIFIED TO DISPENSE TO DUAL ELIGIBLES
1387	1/1/1900	OTHER COVERAGE INDICATOR IS INVALID.
1388	1/1/1900	THE PROCEDURE CODE IS NOT REIMBURSABLE FOR THE RENDERING PROVIDER TYPE AND/OR SPECIALTY.
1389	1/1/1900	THESE SERVICES ARE NOT ALLOWED FOR MEMBERS ENROLLED IN TUBERCULOSIS-RELATED SERVICES ONLY BENEFIT PLAN.
1392	1/1/1900	COMPOUNDS REQUIRE AT LEAST ONE PAYABLE COVERED DRUG.
1393	1/1/1900	DISCHARGE DATE IS BEFORE THE ADMISSION DATE.
1394	1/1/1900	FROM DATE OF SERVICE IS BEFORE ADMISSION DATE.
1395	1/1/1900	ADMISSION DATE IS ON OR AFTER DATE OF RECEIPT OF CLAIM.
1397	1/1/1900	THE FIFTH CONDITION CODE IS INVALID.
1398	1/1/1900	THE FOURTH CONDITION CODE IS INVALID.
1399	1/1/1900	THE PRIMARY CONDITION CODE IS INVALID.
1400	1/1/1900	THE SECOND CONDITION CODE IS INVALID.
1401	1/1/1900	THE SEVENTH CONDITION CODE IS INVALID.
1402	1/1/1900	THE SIXTH CONDITION CODE IS INVALID.
1403	1/1/1900	THE THIRD CONDITION CODE IS INVALID.
1404	1/1/1900	FIFTH OCCURRENCE CODE IS INVALID.
1405	1/1/1900	ONE OR MORE OCCURRENCE CODE(S) IS INVALID IN POSITIONS NINE THROUGH 24.
1406	1/1/1900	SEVENTH OCCURRENCE CODE IS INVALID.
1407	1/1/1900	SIXTH OCCURRENCE CODE IS INVALID.
1408	1/1/1900	THE FOURTH OCCURRENCE CODE IS INVALID.
1409	1/1/1900	EIGHTH OCCURRENCE CODE IS INVALID.
1410	1/1/1900	THE SECOND OCCURRENCE CODE IS INVALID.
1411	1/1/1900	THE THIRD OCCURRENCE CODE IS INVALID.
1412	1/1/1900	A FOURTH OCCURRENCE CODE DATE IS REQUIRED.
1413	1/1/1900	A SECOND OCCURRENCE CODE DATE IS REQUIRED.
1414	1/1/1900	A THIRD OCCURRENCE CODE DATE IS REQUIRED.
1415	1/1/1900	EIGHTH OCCURRENCE CODE DATE IS INVALID.
1416	1/1/1900	EIGHTH OCCURRENCE CODE DATE IS REQUIRED.
1417	1/1/1900	FIFTH OCCURRENCE CODE DATE IS INVALID.
1418	1/1/1900	FIFTH OCCURRENCE CODE DATE IS REQUIRED.
1419	1/1/1900	ONE OR MORE DATE(S) OF SERVICE IS MISSING FOR OCCURRENCE SPAN CODES IN POSITIONS 9 THROUGH 24.
1420	1/1/1900	ONE OR MORE TO DATE(S) OF SERVICE IS INVALID FOR OCCURRENCE SPAN CODES IN POSITIONS THREE THROUGH 24.
1421	1/1/1900	SEVENTH OCCURRENCE CODE DATE IS INVALID.

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EOB Code	Effective Date	Description
1422	1/1/1900	SEVENTH OCCURRENCE CODE DATE IS REQUIRED.
1423	1/1/1900	SIXTH OCCURRENCE CODE DATE IS INVALID.
1424	1/1/1900	SIXTH OCCURRENCE CODE DATE IS REQUIRED.
1425	1/1/1900	THE FOURTH OCCURRENCE CODE DATE IS INVALID.
1426	1/1/1900	THE PRIMARY OCCURRENCE CODE DATE IS INVALID.
1427	1/1/1900	THE SECOND OCCURRENCE CODE DATE IS INVALID.
1428	1/1/1900	THE THIRD OCCURRENCE CODE DATE IS INVALID.
1429	1/1/1900	FIFTH OTHER SURGICAL CODE DATE IS REQUIRED.
1430	1/1/1900	FIRST OTHER SURGICAL CODE DATE IS INVALID.
1431	1/1/1900	FIRST OTHER SURGICAL CODE DATE IS REQUIRED.
1432	1/1/1900	FOURTH OTHER SURGICAL CODE DATE IS INVALID.
1433	1/1/1900	FOURTH OTHER SURGICAL CODE DATE IS REQUIRED.
1434	1/1/1900	ONE OR MORE SURGICAL CODE DATE(S) IS INVALID IN POSITIONS 6 THROUGH 24.
1435	1/1/1900	ONE OR MORE SURGICAL CODE DATE(S) IS MISSING IN POSITIONS 6 THROUGH 24.
1436	1/1/1900	FIFTH OTHER SURGICAL CODE DATE IS INVALID.
1437	1/1/1900	SECOND OTHER SURGICAL CODE DATE IS INVALID.
1438	1/1/1900	SECOND OTHER SURGICAL CODE DATE IS REQUIRED.
1439	1/1/1900	THIRD OTHER SURGICAL CODE DATE IS INVALID.
1440	1/1/1900	THIRD OTHER SURGICAL CODE DATE IS REQUIRED.
1441	1/1/1900	ONE OR MORE OCCURRENCE SPAN CODE(S) IS INVALID IN POSITIONS THREE THROUGH 24.
1442	1/1/1900	SECOND OCCURRENCE SPAN CODE IS INVALID.
1443	1/1/1900	ONE OR MORE FROM DATE(S) OF SERVICE IS MISSING FOR OCCURRENCE SPAN CODES IN POSITIONS THREE THROUGH 24.
1444	1/1/1900	ONE OR MORE TO DATE(S) OF SERVICE IS MISSING FOR OCCURRENCE SPAN CODES IN POSITIONS THREE THROUGH 24.
1445	1/1/1900	THE FROM DATE OF SERVICE FOR THE FIRST OCCURRENCE SPAN CODE IS INVALID.
1446	1/1/1900	THE FROM DATE OF SERVICE FOR THE FIRST OCCURRENCE SPAN CODE IS REQUIRED.
1447	1/1/1900	THE FROM DATE OF SERVICE FOR THE SECOND OCCURRENCE SPAN CODE IS INVALID.
1448	1/1/1900	THE FROM DATE OF SERVICE FOR THE SECOND OCCURRENCE SPAN CODE IS REQUIRED.
1449	1/1/1900	THE TO DATE OF SERVICE FOR THE FIRST OCCURRENCE SPAN CODE IS INVALID.
1450	1/1/1900	THE TO DATE OF SERVICE FOR THE FIRST OCCURRENCE SPAN CODE IS REQUIRED.
1451	1/1/1900	THE TO DATE OF SERVICE FOR THE SECOND OCCURRENCE SPAN CODE IS INVALID.
1452	1/1/1900	THE TO DATE OF SERVICE FOR THE SECOND OCCURRENCE SPAN CODE IS REQUIRED.
1453	1/1/1900	VALUE CODE AMOUNT IS MISSING.
1455	1/1/1900	SERVICE (PROCEDURE CODE/MODIFIER COMBINATION) IS NOT REIMBURSABLE FOR DATE OF SERVICE.
1456	1/1/1900	DETAIL QUANTITY BILLED MUST BE GREATER THAN ZERO.
1457	1/1/1900	HEADER TO DATE OF SERVICE IS AFTER THE ICN DATE.
1458	1/1/1900	THE DETAIL FROM DATE OF SERVICE IS AFTER THE DETAIL TO DATE OF SERVICE.
1459	1/1/1900	DETAIL FROM DATE OF SERVICE IS INVALID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1460	1/1/1900	DETAIL FROM DATE OF SERVICE IS REQUIRED.
1463	1/1/1900	THE REVENUE CODE IS NOT PAYABLE BY THE BENEFIT PLAN FOR THE DATE OF SERVICE.
1465	1/1/1900	THE PROCEDURE CODE IS NOT PAYABLE BY THE BENEFIT PLAN FOR THE DATE OF SERVICE.
1466	1/1/1900	ONE OR MORE DIAGNOSIS CODE(S) IS NOT PAYABLE BY DELAWARE CANCER TREATMENT PROGRAM FOR THE DATE OF SERVICE.
1468	1/1/1900	COMPOUND INGREDIENT QUANTITY MUST BE GREATER THAN ZERO.
1470	1/1/1900	INVALID/MISSING PAYER OR PLAN ID ON CLAIM - USE MS_TXIX.
1488	1/1/1900	THE ASSISTANT SURGEON'S TAXONOMY CODE IN THE HEADER IS INVALID.
1489	1/1/1900	THE REFERRING PROVIDER'S TAXONOMY SUBMITTED IN THE HEADER IS INVALID.
1490	1/1/1900	THE ASSISTANT SURGEON'S TAXONOMY IN THE DETAIL IS INVALID.
1491	1/1/1900	THE ATTENDING PROVIDER'S TAXONOMY CODE IN THE HEADER IS INVALID.
1492	1/1/1900	THE BILLING PROVIDER'S TAXONOMY CODE IS MISSING.
1493	1/1/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IN THE HEADER IS NOT VALID.
1494	1/1/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IS MISSING IN THE HEADER.
1495	1/1/1900	THE PERFORMING PROVIDER'S TAXONOMY CODE IN THE DETAIL IS INVALID.
1496	1/1/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IS MISSING IN THE DETAIL.
1497	1/1/1900	THE RENDERING PROVIDER'S TAXONOMY CODE IN THE DETAIL IS NOT VALID.
1498	1/1/1900	PROCESSED PER POLICY
1499	1/1/1900	PROCESSED PER POLICY
1500	1/1/1900	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	1/1/1900	FOCUSED ADHERENCE INTERVENTION OR MEDICATION DEVICE INSTRUCTION INTERVENTION ARE NOT ALLOWED ON SAME DATE OF SERVICE AS A COMPREHENSIVE MEDICATION REVIEW ANDASSESSMENT.
1502	1/1/1900	PC NOT COVERED EFFECTIVE 9/01/2012.
1503	1/1/1900	A RENDERING PROVIDER NUMBER IS REQUIRED.
1504	1/1/1900	PERFORMING PROVIDER NUMBER IS NOT FOUND.
1505	1/1/1900	THE BILLING PROVIDER'S TAXONOMY CODE IN THE HEADER IS INVALID.
1506	1/1/1900	A NATIONAL PROVIDER IDENTIFIER (NPI) IS REQUIRED FOR THE PERFORMING PROVIDER LISTED IN THE HEADER.
1507	1/1/1900	A RENDERING PROVIDER IS NOT REQUIRED BUT WAS SUBMITTED ON THE CLAIM.
1508	1/1/1900	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	1/1/1900	BILLING PROVIDER INDICATED IS NOT CERTIFIED AS A BILLING PROVIDER.
1510	1/1/1900	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1511	1/1/1900	THE ICD PROCEDURE CODE IS NOT PAYABLE FOR THE DATE OF SERVICE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1512	1/1/1900	THE PROCEDURE CODE/MODIFIER COMBINATION IS NOT PAYABLE FOR THE DATE OF SERVICE.
1514	1/1/1900	FOURTH MODIFIER IS INVALID.
1515	1/1/1900	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SURGICAL PROCEDURE CODE.
1516	1/1/1900	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE REVENUE CODE.
1517	1/1/1900	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1518	1/1/1900	DIAGNOSIS CODE IS RESTRICTED BY MEMBER AGE.
1519	1/1/1900	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1520	1/1/1900	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1521	1/1/1900	PROCEDURE CODE IS NOT ALLOWED ON THE CLAIM FORM/TRANSACTION SUBMITTED.
1522	1/1/1900	SURGICAL PROCEDURE CODE IS NOT ALLOWED ON THE CLAIM FORM/TRANSACTION SUBMITTED.
1523	1/1/1900	AVAILABLE FOR USE
1524	1/1/1900	BILLED AMOUNT EXCEEDS PA AMOUNT.
1525	1/1/1900	FAMILY PLANNING RELATED
1526	1/1/1900	SERVICES BILLED EXCEED PA AMOUNT.
1529	1/1/1900	A MORE SPECIFIC DIAGNOSIS CODE(S) IS REQUIRED.
1530	1/1/1900	CLAIM CONTAINS DUPLICATE SEGMENTS FOR PRESENT ON ADMISSION (POA) INDICATOR.
1531	1/1/1900	INDICATOR FOR PRESENT ON ADMISSION (POA) IS NOT A VALID VALUE.
1532	1/1/1900	CLAIM COUNT OF PRESENT ON ADMISSION (POA) INDICATORS DOES NOT MATCH COUNT OF NON-ADMITTING AND NON-EMERGENCY DIAGNOSIS CODES.
1533	1/1/1900	THE CLAIM DID NOT INCLUDE THE PAYER ID. TXIX WAS ASSIGNED AS THE PAYER FOR THISCLAIM.
1534	1/1/1900	ACCOM REV CODE QTY BILLED NOT EQUAL TO DTL DOS
1535	1/1/1900	EFFECTIVE 04/01/09, THE BADGERCARE PLUS CORE PLAN WILL LIMIT COVERAGE FOR HYPOGLYCEMICS-INSULIN TO HUMALOG AND LANTUS.
1536	1/1/1900	EFFECTIVE 04/01/09, THE BADGERCARE PLUS CORE PLAN WILL LIMIT COVERAGE FOR GLUCOCORTICOIDS-INHALED TO FLOVENT.
1537	1/1/1900	EFFECTIVE 04/01/09, THE BADGERCARE PLUS CORE PLAN WILL LIMIT COVERAGE FOR BROCHODILATORS-BETA AGONISTS TO PROVENTIL HFA AND SEREVENT.
1539	1/1/1900	DAW IS NOT ALLOWED FOR GENERIC DRUG.
1540	1/1/1900	CONTINGENCY PLAN FOR CORE AND HIRSP KIDS - SUSPEND ALL NON-PHARMACY CLAIMS.
1541	1/1/1900	THE PROCEDURE CODE HAS FAMILY PLANNING RESTRICTIONS.
1542	1/1/1900	THE REVENUE CODE HAS FAMILY PLANNING RESTRICTIONS.
1543	1/1/1900	NDC HAS FAMILY PLANNING RESTRICTIONS.
1544	1/1/1900	THE SERVICE IS NOT REIMBURSABLE FOR THE MEMBERS BENEFIT PLAN.
1547	1/1/1900	NO RENDERING PROVIDER STATUS FOUND FOR THE FROM AND TO DATE OF SERVICE.
1548	1/1/1900	NOT USED - CLAIM DATE(S) OF SERVICE MODIFIED TO ADHERE TO DMAP POLICY

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1549	1/1/1900	SUM OF DETAIL MEDICARE PAID AMOUNTS DOES NOT EQUAL HEADER MEDICARE PAID AMOUNT.
1550	1/1/1900	TRANSPLANT SERVICES NOT PAYABLE WITHOUT A TRANSPLANT AQUISITION REVENUE CODE.
1552	1/1/1900	THIS PROCEDURE IS AGE RESTRICTED. MEMBER'S AGE DOES NOT FALL WITHIN THE APPROVED AGE RANGE.
1554	1/1/1900	THE CLAIM TYPE AND DIAGNOSIS CODE SUBMITTED ARE NOT PAYABLE.
1555	1/1/1900	NDC REQUIRES PA. FOLLOW CORE PLAN POLICY FOR PA SUBMISSION.
1564	1/1/2010	PAYMENT MAY BE REDUCED DUE TO SUBMITTED "PRESENT ON ADMISSION" (POA) INDICATOR.
1565	1/1/1900	DAPO OVERRIDE REQUIRED TO DISPENSE LESS THAN THREE MONTH SUPPLY.
1566	1/1/1900	DENIED/CUTBACK. ONE BMI INCENTIVE PAYMENT IS ALLOWED PER MEMBER, PER RENDERINGPROVIDER, PER CALENDAR YEAR.
1567	1/1/1900	CORE PLAN MEMBERS ARE LIMITED TO 25 NON-EMERGENCY OUTPATIENT HOSPITAL VISITS PER ENROLLMENT YEAR.
1569	1/1/1900	PDN SERVICES BILLED ON THIS CLAIM EXCEED 12 HOURS/DAY PER NURSE
1570	1/1/1900	PDN SERVICES BILLED ON THIS CLAIM EXCEED 60 HOURS/WEEK PER NURSE
1571	1/1/1900	PDN SERVICES BILLED ON THIS CLAIM EXCEED 24 HOURS/DAY PER MEMBER
1572	1/1/1900	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	1/1/1900	THE TOTAL OF AMOUNTS BILLED FOR THE DOS ON THE CLAIM EXCEEDS THE ALLOWED DAILYLIMIT FOR PDN SERVICES.
1574	1/1/1900	DIABETIC SUPPLY PREVIOUSLY PAID UNDER EQUIVALENT CODE FOR SAME DATE OF SERVICE.
1575	1/1/1900	PURCHASE OF BLOOD GLUCOSE MONITOR INCLUDES DIABETIC SUPPLIES FOR FIRST 30 DAYS.
1576	1/1/1900	MAXALT REQUIRES PA IF MAXALT OR SUMATRIPTAN NOT PAID WITHIN 365 DAYS.
1577	1/1/1900	DENIED. PROCEDURE CODE 00942 IS ALLOWED ONLY WHEN PROVIDED ON THE SAME DATE OFSERVICE AS PROCEDURE CODE 57520.
1578	1/1/1900	TRANSPLANTS AND TRANSPLANT-RELATED SERVICES ARE NOT COVERED UNDER THE BASIC PLAN.
1579	1/1/1900	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	1/1/1900	THE TRAVEL COMPONENT FOR THIS SERVICE MUST BE BILLED ON THE SAME CLAIM AS THE ASSOCIATED SERVICE.
1582	1/1/1900	CANNOT BILL FOR BOTH ASSAY OF LAB AND OTHER HANDLING/CONVEYANCE OF SPECIMEN.
1588	1/1/1900	QUANTITY DISPENSED MUST BE A MULTIPLE OF THE PACKAGE SIZE.
1589	1/1/1900	DO NOT LEAVE BLANK FIELDS BETWEEN THE MULTIPLE OCCURANCE CODES.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1595	1/1/1990	QUANTITY INDICATED FOR THIS SERVICE EXCEEDS THE MAXIMUM QUANTITY LIMIT ESTABLISHED.
1597	1/1/1900	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	1/1/1900	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	1/1/1900	DIAGNOSIS IN DIAGNOSIS CODE FIELD(S) 1 THROUGH 9 IS MISSING OR INCORRECT.
1601	1/1/1900	ERRORS IN ONE OF THE FOLLOWING DATA ELEMENTS EXCEED THEIR FIELD SIZE: STATEMENTCOVERED FROM DATE, ADMISSION DATE, DATE OF SERVICE, REVENUE CODE.
1602	1/1/1900	OCCURANCE CODE OR OCCURANCE DATE IS INVALID.
1603	1/1/1900	CONDITION CODE MUST BE BLANK OR ALPHA NUMERIC A0-Z9.
1604	1/1/1900	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	1/1/1900	THE FIRST POSITION OF THE ATTENDING UPIN MUST BE ALPHABETIC.
1606	1/1/1900	MODIFIER IS INVALID.
1607	1/1/1900	A DATE OF SERVICE IS REQUIRED WITH THE REVENUE CODE AND HCPCS CODE BILLED.
1608	1/1/1900	THE USE OF VALUE CODE IS INCORRECT.
1609	1/1/1900	A HCPCS CODE IS REQUIRED WHEN CONDITION CODE A6 IS INCLUDED ON THE CLAIM.
1610	1/1/1900	INTERMITTENT PERITONEAL DIALYSIS HOURS MUST BE ENTERED FOR THIS REVENUE CODE.
1611	1/1/1900	VALUE CODES 48 - HOMOGLOBIN READING AND 49 - HEMATOCRIT READING, MUST HAVE A ZERO IN THE FAR RIGHT POSITION.
1612	1/1/1900	THE REVENUE CODE AND HCPCS CODE ARE INCORRECT FOR THE TYPE OF BILL.
1613	1/1/1900	THE REVENUE CODE AND HCPCS CODE ARE INCORRECT FOR THE TYPE OF BILL.
1614	1/1/1900	THE DIAGNOSIS CODE ON THE CLAIM REQUIRES CONDITION CODE A6 BE PRESENT ON THE TYPE OF BILL.
1615	1/1/1900	REVENUE CODE IS NOT VALID FOR THE TYPE OF BILL SUBMITTED.
1616	1/1/1900	THE REVENUE CODE ON THE CLAIM REQUIRES CONDITION CODE 70 TO BE PRESENT FOR THISTYPE OF BILL.
1617	1/1/1900	REVENUE CODE SUBMITTED IS NO LONGER VALID.
1618	1/1/1900	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.
1619	1/1/1900	CONDITION CODES 71, 72, 73, 74, 75, AND 76 CANNOT BE PRESENT ON THE SAME ESRD CLAIM AT THE SAME TIME.
1620	1/1/1900	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.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1621	1/1/1900	IF CONDITION CODES 71 THROUGH 76 EXIST ON THE CLAIM, THEN REVENUE CODES 082X, 083X, 084X, 085X OR 088X MUST ALSO BE PRESENT.
1622	1/1/1900	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	1/1/1900	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	1/1/1900	THE CONDITION CODE IS NOT ALLOWED FOR THE REVENUE CODE.
1625	1/1/1900	THE VALUE CODE 48 (HEMOGLOBIN READING) OR 49 (HEMATOCRIT) IS REQUIRED FOR THE REVENUE CODE/HCPCS CODE COMBINATION.
1626	1/1/1900	THIS REVENUE CODE REQUIRES VALUE CODE 68 TO BE PRESENT ON THE CLAIM.
1627	1/1/1900	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	1/1/1900	REVENUE CODE 082X IS PRESENT ON AN ESRD CLAIM WHICH ALSO CONTAINS REVENUE CODE088X (X FREQUENCY NON EQUAL TO 9).
1629	1/1/1900	REVENUE CODE 082X IS PRESENT ON AN ESRD CLAIM WHICH ALSO CONTAINS REVENUE CODES083X, 084X, OR 085X.
1630	1/1/1900	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	1/1/1900	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	1/1/1900	A VALUE CODE OF A8 OR A9 IS REQUIRED.
1633	1/1/1900	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	1/1/1900	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.
1635	1/1/1900	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	1/1/1900	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.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1637	1/1/1900	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	1/1/1900	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	1/1/1900	X-RAYS AND SOME LAB TESTS ARE NOT BILLABLE ON A 72X CLAIM.
1640	1/1/1900	PAYMENT HAS BEEN REDUCED OR DENIED BECAUSE THE MAXIMUM ALLOWANCE OF THIS ESRD SERVICE HAS BEEN REACHED.
1641	1/1/1900	THE NUMBER OF UNITS BILLED FOR DIALYSIS SERVICES EXCEEDS THE ROUTINE LIMITS.
1642	1/1/1900	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	1/1/1900	THIS IS A DUPLICATE CLAIM. PLEASE ADJUST QUANTITIES ON THE PREVIOUSLY SUBMITTEDAND PAID CLAIM.
1644	1/1/1900	VALID OTHER PAYER DATE REQUIRED.
1645	1/1/1900	OTHER PAYER DATE AFTER CLAIM RECEIPT DATE.
1646	1/1/1900	VALID OTHER PAYER REJECT CODE REQUIRED.
1647	1/1/1900	OTHER PAYER DATE IS INVALID
1648	1/1/1900	REPACKAGED NDCS NOT COVERED.
1649	1/1/1900	REVENUE CODE REQUIRES SUBMISSION OF ASSOCIATED HCPCS CODE
1651	1/1/1900	LENGTH OF OBSERVATION EXCEEDS MAXIMUM LIMIT.
1654	1/1/1900	PROCEDURE NOT PAYABLE FOR THIS BENEFIT PLAN.
1655	1/1/1900	A SPLIT CLAIM IS REQUIRED WHEN THE SERVICE DATES ON YOUR CLAIM OVERLAPS YOUR FEDERAL FISCAL YEAR END (FYE) DATE.
1656	1/1/1900	CONDITION CODE 80 IS PRESENT WITHOUT CONDITION CODE 74. PLEASE VERIFY BILLING.REFERENCE: TRANSMITTAL 477, CHANGE REQUEST 3720 ISSUED FEBRUARY 18, 2005.
1657	1/1/1900	REVENUE CODE BILLED WITH MODIFIER GL MUST CONTAIN NON-COVERED CHARGES.
1658	1/1/1900	HCPCS PROCEDURE CODES G0008, G0009 OR G0010 ARE ALLOWED ONLY WITH REVENUE CODE0771.
1659	1/1/1900	MORE THAN ONE PPV OR INFLUENZA VACCINE BILLED ON THE SAME DATE OF SERVICE FOR THE SAME MEMBER IS NOT ALLOWED.
1660	1/1/1900	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	1/1/1900	THE HCPCS PROCEDURE CODE LISTED FOR REVENUE CODE 0624 IS EITHER INVALID OR NON-REIMBURSEABLE.
1662	1/1/1900	DATE OF SERVICE IS ON OR AFTER JULY 1, 2010 AND TOB IS 72X, VALUE CODE D5 MUSTBE PRESENT.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1663	1/1/1900	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	1/1/1900	MODIFIER V8 OR V9 MUST BE SUMBITTED WITH REVENUE CODE 0821, 0831, 0841, OR 0851.
1665	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. MEMBER ID NOT PRESENT.
1666	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. FINANCIAL PAYER NOT INDICATED.
1667	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. PROVIDER ID NOT PRESENT.
1668	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT RQST. CLAIM ICN/RX NOT FOUND.
1669	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. ORIGINAL ICN NOT PRESENT.
1670	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. MEMBER NOT FOUND.
1671	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. PROVIDER NOT FOUND.
1672	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. ORIGINAL CLAIM ICN NOT FOUND.
1673	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. CLAIM HAS ALREADY BEEN ADJUSTED.
1674	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. A DIFFERENT ADJUSTMENT IS PENDING FOR THIS CLAIM.
1675	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. THIS CLAIM IS IN POST PAY BILLING FOR THIRD PARTY LIABILITY PAYMENT.
1676	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. CLAIM CAN NO LONGER BE ADJUSTED. CONTACT PROVIDER SERVICES FOR FURTHER INFORMATION.
1677	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. THE CLAIM TYPE OF THE ADJUSTMENT DOES NOT MATCH THE CLAIM TYPE OF THE ORIGINAL CLAIM.
1678	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. MEMBER ID NUMBER ON THE CLAIM AND ON THE ADJUSTMENT REQUEST DO NOT MATCH.
1679	1/1/1900	UNABLE TO PROCESS YOUR ADJUSTMENT REQUEST. PROVIDER ID/OR BILLING ADDRESS ON THE CLAIM AND ON THE ADJUSTMENT REQUEST DO NOT MATCH.
1680	1/1/1900	MODIFIER V5, V6, OR V7 MUST BE INCLUDED ON THE LATEST LINE ITEM DATE OF SERVICEBILLING REVENUE CODE 0821.
1681	1/1/1900	CONDITION CODE 73 FOR SELF CARE CANNOT EXCEED A QUANTITY OF 15.
1682	1/1/1900	THE INITIAL RENTAL OF A NEGATIVE PRESSURE WOUND THERAPY PUMP IS LIMITED TO 90 DAYS; MEMBER LIFETIME.
1683	1/1/1900	ADDITIONAL RENTAL OF A NEGATIVE PRESSURE WOUND THERAPY PUMP IS LIMITED TO 90 DAYS IN A 12 MONTH PERIOD.
1684	1/1/1900	THE CANISTER, DRESSINGS AND RELATED SUPPLIES ARE INCLUDED AS PART OF THE REIMBURSEMENT FOR THE NEGATIVE PRESSURE WOUND THERAPY PUMP.
1685	1/1/1900	BILLING PROVIDER TYPE AND SPECIALTY IS NOT ALLOWABLE FOR THE PLACE OF SERVICE.
1686	1/1/1900	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
1689	1/1/1900	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	1/1/1900	QUANTITY INDICATED FOR THIS SERVICE EXCEEDS THE MAXIMUM QUANTITY LIMIT ESTABLISHED BY THE NATIONAL CORRECT CODING INITIATIVE.
1691	1/1/1900	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	1/1/1900	ADJUSTMENT AND ORIGINAL CLAIM DO NOT HAVE THE SAME FINANICAL PAYER
1696	1/1/1900	THERE ARE NO SEPARATELY REIMBURSABLE DIALYSIS SERVICES ON THIS ESRD CLAIM
1697	1/1/1900	PRICING ADJUSTMENT - REDUCTION OF REIMBURSEMENT WHEN SERVICE IS RENDERED IN A HOSPITAL OR AMBULATORY SURGERY CENTER.
1702	1/1/1900	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	1/1/1900	CONSULTANT REVIEW HAS NOT OCCURRED DUE TO INSUFFICIENT JUSTIFICATION PROVIDED ON PHARMACY SPECIAL HANDLING REQUEST.
1704	1/1/1900	BOOSTER COVID VACCINE ADMINISTRATION
1705	1/1/1900	MENTAL HEALTH INJECTABLE DRUGS ONLY COVERED THROUGH POS FOR MEMBERS RESIDING INLONG TERM CARE FACILITIES. ALL OTHER PTs BILL ON MEDICAL CLAIMS.
1706	1/1/1900	ANXIOLYTIC INJECTIONS ARE ONLY COVERED THROUGH POS FOR MEMBERS RESIDING IN LTCFACILITIES. ALL OTHER PATIENTS REQUIRE PA.
1710	1/1/1900	MEMBER ENROLLED IN MEDICAID
1712	1/1/1900	CLAIM DENIED FOR WRONG SURGICAL OR OTHER INVASIVE PROCEDURE PERFORMED ON A PATIENT.
1713	1/1/1900	CLAIM DENIED FOR WRONG SURGICAL OR OTHER INVASIVE PROCEDURE PERFORMED ON A PATIENT.
1715	1/1/1900	TOOTH NUMBER IS AGE RESTRICTED. MEMBER'S AGE DOES NOT FALL WITHIN THE APPROVEDAGE RANGE.
1716	1/1/1900	DISCHARGE HOUR IS INVALID FORMAT.
1717	1/1/1900	DETAIL DATES OF SERVICE MUST SPAN 1 MONTH FOR PROCEDURE CODE BILLED.
1718	1/1/1900	DETAIL DATES OF SERVICE MUST SPAN 1 MONTH FOR REVENUE CODE BILLED.
1719	1/1/1900	BILLED AMOUNT CAN NOT EXCEED 1 MILLION DOLLARS.
1720	1/1/1900	MEDICARE PAID AMOUNT GREATER THAN OR EQUAL TO MEDICARE ALLOWED AMOUNT.
1721	1/1/1900	TOTAL DAYS STAY DOES NOT EQUAL THE COVERED DAYS. PLEASE VERIFY YOUR BILLING, CORRECT AND RESUBMIT.
1722	1/1/1900	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	1/1/1900	PROCEDURE REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASERESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1724	1/1/1900	CLAIM REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASE RESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
1725	1/1/1900	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	1/1/1900	CLAIM BILLED FOR AN ACCOMMODATION REVENUE CODE IN A SUBCATEGORY OTHER THAN REHAB. PHYSICAL REHAB PROVIDER NUMBER/TAXONOMY CANNOT BE CONSIDERED AS PRESENT.
1727	1/1/1900	MODIFIER HO OR HP INCONSISTENT WITH PROVIDER TAXONOMY.
1728	1/1/1900	POS CLAIM WAS SUBMITTED BEYOND THE 100 DAY TIMELY FILING LIMIT.
1729	1/1/1900	DIAGNOSIS REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASERESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
1730	1/1/1900	SEALANT AND SURFACE COMBINATION INVALID.
1731	1/1/1900	RESPITE CARE NOT COVERED IN NURSING HOME FACILITY.
1732	1/1/1900	DRUG NAME REQUIRED.
1733	1/1/1900	CLAIM REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASE RESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
1734	1/1/1900	TOOTH NUMBER AND PROCEDURE REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH ISMISSING. PLEASE RESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
1735	1/1/1900	PLEASE RESUBMIT AS A POS CLAIM.
1736	1/1/1900	MULTIPLE PERFORMING PROVIDERS. MUST HAVE THE SAME PERFORMING PROVIDER FOR ALL DETAILS.
1737	1/1/1900	PRESCRIBER NAME MISMATCH OR INVALID.
1738	1/1/1900	PROVIDER NOT ELIGIBLE TO PROVIDE SERVICES TO QMB MEMBER.
1739	1/1/1900	MEMBER DATE OF DEATH INVALID.
1740	1/1/1900	MEMBER DATE OF BIRTH INVALID.
1741	1/1/1900	SERVICE COVERED BY PACE.
1742	1/1/1900	TPL AMOUNT APPLIED AND PATIENT RESPONSIBILITY IS ZERO.NO PAYMENT ALLOWED.
1743	1/1/1900	TPL ONLY REQUIRED AT THE HEADER.
1744	1/1/1900	TPL ONLY REQUIRED AT THE DETAIL.
1745	1/1/1900	TPL NOT BALANCED FOR CLAIM.
1746	1/1/1900	MEMBER DATE OF DEATH DOES NOT MATCH FILE.
1747	1/1/1900	DATE OF SERVICE IS AFTER MEMBER DATE OF DEATH ON FILE.
1748	1/1/1900	MEMBER BIRTH DATE DOES NOT MATCH FILE.
1749	1/1/1900	MEMBER GENDER DOES NOT MATCH FILE.
1750	1/1/1900	MEMBER NOT ELIGIBLIE FOR VFC PROCEDURE.
1752	1/1/1900	QUANITY UNITS BILLED OUTSIDE THE LIMITS.
1753	1/1/1900	PROCEDURE REQUIRES BILLING OF 5 DAYS OF SERVICES.
1754	1/1/1900	PROCEDURE REQUIRES BILLING OF 30 DAYS OF SERVICES.
1755	1/1/1900	PROVIDER NOT CERTIFIED FOR ANESTEHESIA PROCEDURE.
1756	1/1/1900	REVENUE CODE NOT BILLABLE FOR RENDERING PROVIDER SERVICE LOCATION.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
1757	1/1/1900	REVENUE CODE NOT BILLABLE FOR BILLING PROVIDER SERVICE LOCATION.
1758	1/1/1900	REVENUE CODE NOT BILLABLE FOR MEMBER SERVICE LOCATION.
1759	1/1/1900	LOCKIN PLANS CAN NOT OVERLAP DATE OF SERVICE.
1760	1/1/1900	DATES OF SERVICES SPAN ICD-9 AND ICD-10 TIME FRAMES.
1761	1/1/1900	INVALID PROCEDURE CODE MODIFIER COMBINATION FOR CLIA ON FILE.
1762	1/1/1900	TOOTH NUMBER INVALID FOR TOOTH SURFACE F AND I.
1763	1/1/1900	TOOTH NUMBER INVALID FOR TOOTH SURFACE B AND O.
1764	1/1/1900	MEMBER HAS ILLEGAL ALIEN PLAN WITH DCTP COVERAGE.
1765	1/1/1900	CLAIM SUSPENDED FOR MANUAL REVIEW
1766	1/1/1900	ICD CODE IS AGE RESTRICTED. MEMBER'S AGE DOES NOT FALL WITHIN THE APPROVED AGERANGE.
1767	1/1/1900	REVENUE CODE IS AGE RESTRICTED. MEMBER'S AGE DOES NOT FALL WITHIN THE APPROVEDAGE RANGE.
1768	1/1/1900	TPL PAY AND CHASE SERVICES
1769	1/1/1900	INPATIENT CLAIM PROCESSED USING DISCHARGE RATE.
1770	1/1/1900	PAID ACCORDING TO MEDICAID ALLOWED AMOUNT
1794	1/1/1900	ATTACHMENT TRANSMISSION CODE (PWK02) SUBMITTED ON 837 CLAIM MUST BE "BM"-BY MAIL ONLY. PLEASE CORRECT AND RESUBMIT.
1798	1/1/1900	PROVIDER HAS MEDICARE ONLY INFORMATIONAL CONTRACT
1801	1/1/1900	REFILL INDICATOR INVALID.
1807	1/1/1900	UNABLE TO PROCESS. CALL PROVIDER SERVICES.
1808	1/1/1900	BILLING PROVIDER ID NOT ON FILE.
1809	1/1/1900	RENDERING PROVIDER IS NOT CERTIFIED.
1810	1/1/1900	NPI IS REQUIRED FOR BILLING PROVIDER.
1815	1/1/1900	QMB-ONLY MEMBER RESTRICTED TO MEDICARE CROSSOVER CLAIMS.
1816	1/1/1900	NDC NOT REIMBURSABLE FOR DATE OF SERVICE
1818	1/1/1900	HEADER FACILITY PROVIDER NUMBER IS NOT FOUND.
1819	1/1/1900	VERIFY BILLED AMOUNT AND QUANTITY BILLED. IF CORRECT, RESUBMIT THE CLAIM.
1821	1/1/1900	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	1/1/1900	NOT USED - NATIONAL CORRECT CODING INITIATIVES. DMAP HAS APPROVED THE PROCEDUREF OR THIS DATE OF SERVICE.
1824	1/1/1900	MCO ID IS INVALID OR NOT PRESENT ON ENCOUNTER CLAIM.
1825	1/1/1900	PROVIDER ATTESTATION NOT FOUND FOR 340B CLAIMS
1830	1/1/1900	RENDERING PROVIDER NOT ELIGIBLE/REVALIDATED - RECYCLE 21 DAYS
1831	1/1/1900	RENDERING PROVIDER NOT ELIGIBLE/REVALIDATED - DENY
1832	1/1/1900	BILLING PROVIDER NOT ELIGIBLE/REVALIDATED - RECYCLE 21 DAYS
1833	1/1/1900	BILLING PROVIDER NOT ELIGIBLE/REVALIDATED - DENY
1897	1/1/1900	THE FACILITY PROVIDER'S TAXONOMY CODE AT THE DETAIL IS INVALID, MISSING, OR DOES NOT MATCH THE TAXONOMY ON FILE.

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EOB Code	Effective Date	Description
1903	1/1/1900	THE FACILITY PROVIDER'S TAXONOMY CODE IN THE HEADER IS INVALID, MISSING, OR DOES NOT MATCH THE TAXONOMY ON FILE
1920	1/1/1900	THE REFERRING PROVIDER'S TAXONOMY SUBMITTED AT THE DETAIL IS INVALID
1922	1/1/1900	THE REFERRING PROVIDER'S TAXONOMY SUBMITTED AT THE DETAIL IS MISSING
1929	1/1/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR REFERRING PROVIDER LISTEDIN THE HEADER.
1930	1/1/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE FACILITY PROVIDER LISTED IN THE HEADER.
1932	1/1/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE OTHER PROVIDER LISTEDIN THE HEADER.
1933	1/1/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE OTHER PROVIDER LISTEDAT THE DETAIL.
1934	1/1/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR THE RENDERING PROVIDER LISTED AT THE DETAIL.
1935	1/1/1900	THE NATIONAL PROVIDER IDENTIFIER (NPI) IS INVALID FOR REFERRING PROVIDER LISTEDIN THE DETAIL.
1937	1/1/1900	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	1/1/1900	INVALID INTERNAL OTHER PROV SPECIFIED - HDR
1942	1/1/1900	INVALID INTERNAL OTHER PROV SPECIFIED - DTL
2001	1/1/1900	MEMBER ID IS INCORRECT. BILL USING THE FIRST 9 NUMERIC VALUES ON THE ID CARD AND NO LEADING ZEROS.
2012	1/1/1900	INDIVIDUAL BILLING PROVIDER MUST ALSO BE THE RENDERING PROVIDER
2013	1/1/1900	GROUP BILLING PROVIDER NOT ALLOWED FOR CLAIM TYPE
2020	1/1/1900	PROVIDER LICENSE EXPIRED
2022	1/1/1900	DATE OF SERVICE BEFORE MEMBER'S DATE OF BIRTH
2025	1/1/1900	MEMBER NOT COVERED FOR OUTPATIENT PHARM BENEFITS FOR DOS (HPE SERVICE MODIFIER)
2030	1/1/1900	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	1/1/1900	BABY'S GENDER CODE IS MISSING OR INVALID.
2032	1/1/1900	BABY OVER AGE ONE-REBILL UNDER BABY'S MEDICAID ID
2034	1/1/1900	PHARMACY CLAIMS NOT COVERED FOR INM MEMBERS
2037	1/1/1900	MEMBER ID HAS CHANGED. NO ACTION REQUIRED.
2040	1/1/1900	NDC IS OBSOLETE FOR THE DATE OF SERVICE.
2054	1/1/1900	UNABLE TO DETERMINE MEMBER AID CATEGORY
2060	1/1/1900	MEMBER IS NOT ELIGIBLE FOR WAIVER SERVICES
2222	1/1/1900	POLICY NOT CURRENTLY ENFORCED.
2257	1/1/1900	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.

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EOB Code	Effective Date	Description
2268	1/1/1900	MEMBER ENROLLED IN MEDICARE PART D. CLAIM IS EXCLUDED FROM DRUG REBATE INVOICING.
2277	1/1/1900	ADMIT HOUR INVALID
2302	1/1/1900	FLUORIDE AND PROPHYLAXIS BUNDLED LIMITED TO ONE PER PROVIDER PER DAY
2304	1/1/1900	MULTIPLE RADIATION THERAPY MANAGEMENT SESSIONS BILLED SAME DAY
2305	1/1/1900	NARRATIVE AND TOOTH NUMBER OR LETTER REQUIRED FOR PALLIATIVE TREATMENT.
2306	1/1/1900	OCCUPATIONAL THERPAY EVALUATION BILLED SAME DAY AS OCCUPATIONAL THERAPY SESSION
2307	1/1/1900	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	1/1/1900	PHYSICAL THERPAY EVALUATION BILLED SAME DAY AS PHYSICAL THERAPY SESSION
2311	1/1/1900	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	1/1/1900	PROCEDURE REQUIRES REVIEW OF SUPPORTING DOCUMENTATION WHICH IS MISSING. PLEASERESUBMIT THE CLAIM WITH SUPPORTING DOCUMENTATION.
2316	1/1/1900	SERVICE LIMITED TO EVERY SIX MONTHS
2317	1/1/1900	SERVICE LIMITED TO EVERY THREE YEARS
2318	1/1/1900	SERVICE LIMITED TO FIFTEEN PER YEAR
2319	1/1/1900	SERVICE LIMITED TO FIVE PER LIFETIME
2320	1/1/1900	SERVICE LIMITED TO FOUR LIFETIME
2324	1/1/1900	SERVICE LIMITED TO ONE PER 210 DAYS
2325	1/1/1900	SERVICE LIMITED TO ONE PER 280 DAYS
2326	1/1/1900	SERVICE LIMITED TO ONE PER DAY
2327	1/1/1900	SERVICE LIMITED TO ONE PER LIFETIME
2330	1/1/1900	SERVICE LIMITED TO ONE PER YEAR
2331	1/1/1900	SERVICE LIMITED TO TWO DOSES OF VARICELLA AGES 1 THROUGH 19
2332	1/1/1900	SERVICE LIMITED TO TWO PER LIFETIME
2333	1/1/1900	SERVICE ROUTINELY COVERED ONCE PER 36 MONTHS. PAYMENT HAS ALREADY BEEN MADE TOYOU OR ANOTHER PROVIDER. THIS CLAIM WILL NOT BE PAID.
2334	1/1/1900	SERVICE ROUTINELY COVERED ONCE PER SIX MONTHS. PAYMENT HAS ALREADY BEEN MADE TOYOU OR ANOTHER PROVIDER.
2335	1/1/1900	SERVICES LIMITED TO ONE EVERY 45 DAYS.
2336	1/1/1900	SPECIFIED SERVICES BILLED SAME DAY SAME PROVIDER
2337	1/1/1900	SPEECH THERAPY EVALUATION BILLED SAME DAY AS SPEECH THERAPY SESSION
2338	1/1/1900	SURGERY PROCEDURE BILLED SAME DAY AS HOSPITAL VISIT SAME PROVIDER
2339	1/1/1900	SURGERY PROCEDURE BILLED WITHIN 45 DAY PERIOD PRIOR TO OFFICE OR HOME VISIT SAME PROVIDER
2340	1/1/1900	SURGERY PROCEDURE BILLED WITHIN THREE DAYS OF HOSPITAL ADMISSION BY SAME PROVIDER

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
2342	1/1/1900	THE HCPCS PROCEDURE CODE BILLED IS INCLUDED IN THE REIMBURSEMENT FOR THE PRIMARY SERVICE/PROCEDURE
2344	1/1/1900	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	1/1/1900	YOU ARE BILLING A HOSPITAL READMISSION FOR THE SAME ADMITTING DIAGNOSIS WITHIN10 DAYS OF INITIAL DISCHARGE. THIS CLAIM WILL NOT BE PAID.
2346	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	BILLING PROVIDER NUMBER IS FOR AN INDIVIDUAL, THEREFORE, THE DETAIL PERFORMINGPROVIDER NUMBER MUST BE THE SAME AS THE BILLING PROVIDER NUMBER.
2355	1/1/1900	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	1/1/1900	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	1/1/1900	DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE PROCEDURE CODE BILLED. PLEASE REVIEW, CORRECT, OR SUBMIT FURTHER DOCUMENTATION
2359	1/1/1900	THIS PROCEDURE IS NOT REIMBURSABLE WHEN PERFORMED AT THE SAME TIME OR IN IMMEDIATE SEQUENCE WITH ANOTHER SURGICAL PROCEDURE
2360	1/1/1900	PROCEDURES DESIGNATED IN CPT AS SEPARATE PROCEDURES ARE INCLUDED IN THE REIMBURSEMENT FOR THE PRIMARY PROCEDURE
2361	1/1/1900	AN ANESTHESIA RECORD FOR THIS SURGICAL PROCEDURE IS NEEDED IN ORDER TO DETERMINE PROPER RESOLUTION OF THIS CLAIM.PLEASE RESUBMIT WITH THIS DOCUMENTATION
2362	1/1/1900	REVIEW THE PRACTITIONER MANUAL - USE THE SPECIFIC HCPCS PROCEDURE CODE FOR THESERVICE RENDERED
2363	1/1/1900	DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE DATE OF SERVICE BILLED. PLEASE REVIEW, CORRECT, OR SUBMIT FURTHER DOCUMENTATION.
2368	1/1/1900	THE OPERATIVE NOTE SHOULD CLEARLY DOCUMENT WHAT THE ASSISTANT SURGEON DID DURING THE OPERATIVE SESSION.
2377	1/1/1900	COMPLETE UPPER DENTURES ALLOWED ONCE EVERY FIVE YEARS
2378	1/1/1900	COMPLETE LOWER DENTURES ALLOWED ONCE EVERY 5 YEARS
2379	1/1/1900	PARTIAL UPPER DENTURES ALLOWED ONCE EVERY 5 YEARS

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EOB Code	Effective Date	Description
2380	1/1/1900	PARTIAL LOWER DENTURES ALLOWED ONCE EVERY 5 YEARS
2381	1/1/1900	ADJUSTMENTS ALLOWED ONLY ONCE EVERY 6 MONTHS
2382	1/1/1900	1 DENTURE RELINE EVERY 2 YEARS
2386	1/1/1900	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	1/1/1900	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	1/1/1900	YOU HAVE BILLED FOR PROPHYLAXIS FOR ANOTHER DATE OF SERVICE WITHIN 6 MONTHS. IFADDITIONAL PROPHYLAXIS MEDICALLY NECESSARY, SUBMIT REQUEST FOR PRIOR AUTHORIZATION.
2389	1/1/1900	THIS CLAIM IS DENIED AS A DUPLICATE BECAUSE YOU ARE BILLING MORE THAN ONE PROPHYLAXIS ON THE SAME DAY.
2390	1/1/1900	ANOTHER PROVIDER HAS ALREADY BEEN PAID FOR THE EXTRACTION OF THIS TOOTH
2391	1/1/1900	PAYMENT HAS ALREADY BEEN MADE TO YOU OR ANOTHER PROVIDER FOR THE EXTRACTION OFTHIS TOOTH. REVIEW. IF CORRECT, RESUBMIT WITH DOCUMENTATION.
2399	1/1/1900	INVALID - MEDICARE DEDUCTIBLE PRESENT ON INTERIM BILL
2401	1/1/1900	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	1/1/1900	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	1/1/1900	DOCUMENTATION DOES NOT JUSTIFY SERVICES BILLED
2404	1/1/1900	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	1/1/1900	DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE THE NUMBER OF UNITS BILLED. PLEASE REVIEW, CORRECT NUMBER OF UNITS BILLED OR SUBMIT FURTHER DOCUMENTATION.
2445	1/1/1900	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	1/1/1900	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	1/1/1900	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
2450	1/1/1900	BILLING A PROCEDURE CODE THAT REQUIRES AN ATTACHMENT FOR MANUAL PRICING.
2453	1/1/1900	PLEASE RESUBMIT WITH CONSENT OR AWARENESS FORM PER SECTION 2.5 OF THE PRACTITIONER PROVIDER POLICY MANUAL

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EOB Code	Effective Date	Description
2454	1/1/1900	THE FORM ATTACHED IS NOT LEGIBLE
2455	1/1/1900	THE ATTACHED FORM MUST BE COMPLETED IN ITS ENTIRETY
2456	1/1/1900	FEDERAL STERILIZATION CONSENT FORM IS REQUIRED
2458	1/1/1900	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	1/1/1900	THIS MEMBER IS ENROLLED IN A MANAGED CARE ORGANIZATION.THE SERVICE BILLED IS ONLY COVERED IF PROVIDED BY THAT PLAN.
2460	1/1/1900	CLIENT 21 OR OVER ON DATE OF SERVICE. NOT ELIGIBLE FOR EPSDT SERVICES
2462	1/1/1900	PROCEDURE WITHOUT A MODIFIER INCONSISTENT WITH THE PLACE OF SERVICE.
2465	1/1/1900	REVENUE CODE BILLED NOT ALLOWED FOR PROVIDER WITHOUT JUSTIFICATION.
2467	1/1/1900	EOB PAID AMOUNT DOES NOT MATCH AMOUNT IN AMOUNT PAID BOX ON CLAIM FORM
2468	1/1/1900	PART A EXHAUSTED CLAIMS FOR INPATIENT SERVICES MUST BE SUBMITTED ON PAPER WITHAN EOMB THAT CLEARLY STATES THE BENEFIT IS EXHAUSTED.
2469	1/1/1900	CLIENT HAS MEDICARE. BILL MEDICARE FIRST OR TRANSMIT A VALID DENIAL REASON CODE.
2470	1/1/1900	CLIENT ON EOB DOES NOT MATCH CLIENT ON THE CLAIM FORM
2471	1/1/1900	CLIENT HAS MEDICARE. BILL MEDICARE FIRST OR ATTACH MEDICARE DENIAL.
2472	1/1/1900	INVALID TPL VOUCHER ATTACHED. TPL VOUCHER IS EITHER FOR ANOTHER INDIVIDUAL, DIFFERENT DATES OF SERVICE, OR DIFFERENT INSURANCE CARRIER. PLEASE CORRECT AND RESUBMIT.
2473	1/1/1900	INSURANCE PAYMENT/DENIAL INFORMATION IS INCOMPLETE
2474	1/1/1900	DENIAL REASON ON EXPLANATION OF BENEFITS IS NOT SUFFICIENT OR IS UNACCEPTABLE.
2475	1/1/1900	MEDICAID WILL NOT COVER SERVICES DENIED BY THE PRIMARY INSURANCE BECAUSE THE RULES OF THE PRIMARY INSURANCE WERE NOT FOLLOWED.
2476	1/1/1900	MEMBBER HAS OTHER INSURANCE. ATTACH OTHER INSURANCE PAYMENT OR DENIAL.
2477	1/1/1900	ATTACH A COPY OF THE INSURANCE EOB WITH THE DENIAL REASON.
2478	1/1/1900	DENIAL REASON ON EXPLANATION OF BENEFITS IS NOT SUFFICIENT OR IS UNACCEPTABLE.
2479	1/1/1900	CLIENT ON EOB DOES NOT MATCH CLIENT ON THE CLAIM FORM
2480	1/1/1900	EOMB INFORMATION IS UNDER REVIEW
2481	1/1/1900	MEMBER HAS MORE THAN ONE INSURANCE CARRIER. RESUBMIT WITH ALL EOB'S
2482	1/1/1900	PART OF THIS CLM IS COVRD BY OTHER INS. RESUBMIT WITH EOB FOR COVERED CHARGES
2483	1/1/1900	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	1/1/1900	THE MEDICARE EOMB WAS ATTACHED TO THE CLAIM BUT THE PATIENT'S MEDICARE SUPPLEMENT PLAN VOUCHER WAS MISSING. PLEASE ATTACH AND RESUBMIT.

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EOB Code	Effective Date	Description
2485	1/1/1900	INVALID TPL VOUCHER ATTACHED. TPL VOUCHER IS EITHER FOR ANOTHER INDIVIDUAL, DIFFERENT DATES OF SERVICE, OR DIFFERENT INSURANCE CARRIER. PLEASE CORRECT AND RESUBMIT.
2486	1/1/1900	A SEPARATE CLAIM MUST BE SUBMITTED FOR EACH CLAIM NUMBER ON THE INSURANCE EOB.
2487	1/1/1900	THIS CLAIM IS DENIED BECAUSE THE DATE OF SUBMISSION IS OVER SIX MONTHS FROM THEDATE OF THE TPL VOUCHER.
2490	1/1/1900	AN OPERATIVE REPORT IS REQUIRED IN ORDER TO DETERMINE PROPER REIMBURSEMENT.
2491	1/1/1900	TPL VOUCHER PAID DATE IS MISSING. PLEASE RECOPY VOUCHER SO THE PAID DATE APPEARS AND RESUBMIT.
2493	1/1/1900	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	1/1/1900	THE PRESCRIPTION ORIGIN CODE IS INVALID. THIS CLAIM WILL NOT BE PAID
2495	1/1/1900	NET CLAIMS NOT COVERED FOR CERTAIN AID CATEGORIES
2496	1/1/1900	Header paid amount exceeds billed amount
2497	1/1/1900	DAILY DOSAGE IS EXCESSIVE. VERIFY UNITS AND DAY SUPPLY FIELDS ARE CORRECTLY POPULATED. CONTACT THE HPE PROVIDER HELP DESK FOR ADDITIONAL ASSISTANCE
2498	1/1/1900	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	1/1/1900	ADJUDICATION DATE OLDER THAN 365 DAYS.
2500	1/1/1900	MULTIPLE CLAIMS FOUND.
2501	1/1/1900	REVERSAL NOT ALLOWED FOR CLAIM STATUS.
2502	1/1/1900	REVERSAL NOT PROCESSED.
2503	1/1/1900	YOU ARE BILLING A "SICK" OFFICE VISIT CODE WITH A "WELL" DIAGNOSIS. REVIEW. CORRECT. SEE PRACTITIONER MANUAL, PROVIDER SPECIFIC POLICY, PREVENTIVE MEDICINESECTION.
2504	1/1/1900	PATIENT MUST BE AT LEAST 21 YEARS OF AGE WHEN SIGNING THE CONSENT FORM.
2505	1/1/1900	STERILIZATION DID NOT MEET THE 30 DAY WAITING PERIOD.
2506	1/1/1900	DATE OF STERILIZATION MUST NOT BE MORE THAN 180 DAYS AFTER THE PATIENT SIGNED THE CONSENT FORM.
2507	1/1/1900	PREMATURE DELIVERY WITH STERILIZATION REQUIRES EXPECTED DATE OF DELIVERY.
2508	1/1/1900	PERSON OBTAINING CONSENT MUST SIGN AND DATE THE CONSENT FORM THE SAME DAY AS THE PATIENT.
2509	1/1/1900	DATES OF THE SURGERY ON THE CONSENT FORM AND CLAIM DO NOT MATCH.
2510	1/1/1900	PHYSICIAN MUST SIGN AND DATE THE CONSENT FORM ON OR AFTER THE DATE OF SERVICE.
2511	1/1/1900	BONY IMPACTED WISDOM TEETH PROCEDURES MUST BE SUBMITTED ON A PROFESSIONAL CLAIMFORM.

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EOB Code	Effective Date	Description
2512	1/1/1900	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	1/1/1900	MEDICARE PART C CLAIM FILED FOR MEMBER. MEMBER DOES NOT HAVE MEDICARE PART C ADVANTAGE PLAN ON FILE.
2514	1/1/1900	THIS CLAIM APPEARS TO BE A DUPLICATE OF ANOTHER CLAIM. PLEASE RESUBMIT WITH DISCHARGE AND ADMIT HOURS COMPLETED.
2515	12/8/2017	INTERIM BILLING: SUBMIT THE TOTAL CHARGES FROM THE ORIGINAL FROM DATE OF SERVICE (ADMIT DATE) ON ALL SUBSEQUENT INTERIM CLAIMS.
2516	1/31/2018	INTERIM BILLING: PLEASE CONTACT GAINWELL TECHNOLOGIES PROVIDER RELATIONS FOR INSTRUCTIONS REGARDING SUBMISSION OF INTERIM CLAIMS.
2517	1/1/2016	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	1/1/2014	PLEASE ATTACH THE REQUIRED NOTICE OF DENIAL FROM THE MCO TO INDICATE SERVICES HAVE BEEN EXHAUSTED. ONE PER CALENDAR YEAR IS REQUIRED.
2519	1/1/2014	THE DOCUMENTATION YOU HAVE ATTACHED DOES NOT MATCH THE CLAIM.
2520	1/1/2014	SERVICES ARE OUTSIDE THE PARAMETERS OF THE PERIODICITY SCHEDULE.
2521	1/1/2014	CLIENT IS ONLY ELIGIBLE FOR PAYMENT OF MEDICARE PREMIUMS AND IS NOT ELIGIBLE FOR MEDICAID SERVICES. THIS CLAIM WILL NOT BE PAID.
2603	1/1/1900	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	1/1/1900	MEMBER IS ASSIGNED TO A LOCKIN PLAN. SERVICES MUST BE RENDERED BY THE LOCKIN PROVIDER.
2613	1/1/1900	MSCAN ENCOUNTER SUBMITTED WITH $0 CCO PD AMT AND CARC WAS MISSING OR INVALID
2614	1/1/1900	CCO DENIED ENCOUNTERS BASED ON THE CAS REASON CODES
2617	1/1/1900	MSCHIP ENCOUNTER SUBMITTED WITH $0 CCO PD AMT AND CARC WAS MISSING OR INVALID
2618	1/1/1900	CCO RENDERING PROVIDER NOT FOUND ON AFFILIATION FILE
2620	1/1/1900	CCO CHP BLN PROVIDER NOT FOUND ON AFFILIATION FILE
2622	1/1/1900	OUT OF NETWORK BILLING PROVIDER NOT CHIP PROVIDER
2631	1/1/1900	M/I COMPOUND INGREDIENT DRUG COST
2633	1/1/1900	MISSING OR INVALID PRODUCT/SERVICE ID QUALIFIER
2638	1/1/1900	THIRD-PARTY COVERAGE AND NO AMOUNT WAS RECOVERED
2668	1/1/1900	72 HOUR EMERGENCY FILL
2669	1/1/1900	DRUG NOT ALLOWED FOR 72 HOUR FILL
2671	1/1/1900	NOT ALL COMPOUND INGREDIENTS APPROVED
2672	1/1/1900	COMPOUND CLAIMS MUST BE SUBMITTED VIA WEB PORTAL
2678	1/1/1900	CCO DID NOT SUBMIT ENCOUNTER CLAIM WITHIN 30 DAYS OF ORIGINAL RECEIPT FROM PHARMACY

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EOB Code	Effective Date	Description
2679	1/1/1900	ENCOUNTER ADJUSTMENT CLAIM TOO OLD
2693	1/1/1900	MEMBER IS ELIGIBLE FOR LONG TERM CARE AND THE DATE OF SERVICE FALLS WITHIN A STOP PAYMENT SEGMENT.
2698	1/1/1900	340B CLAIM SUBMISSION CLARIFICATION/COST BASIS CODE COMBO INVALID OR MISSING
2706	1/1/1900	MEMBER'S AGE IS LESS THAN RECOMMENDED AGE FOR DRUG. PA REQUIRED.
2707	1/1/1900	CALCULATED DAILY DOSE LESS THAN MINIMUM DAILY DOSE.
2708	1/1/1900	NO DOSE INFORMATION FOR AGE.
2709	1/1/1900	NO DOSE INFORMATION FOR AGE; DIFFERENT AGE WILL BE USED TO CALCULATE DOSING.
2715	1/1/1900	MAX ADULT DAILY DOSE EXCEEDED
2716	1/1/1900	MAX PEDIATRIC DAILY DOSE EXCEEDED
2717	1/1/1900	MAX GERIATRIC DAILY DOSE EXCEEDED
2815	1/1/1900	NEW ADMIN PROVIDER HOLD
2819	1/1/1900	REFERRING PROVIDER NPI MISSING FOR ADMIT SOURCE
3001	1/1/1900	MEMBER IS NOT COVERED FOR THE NDC BILLED FOR THE DATE OF SERVICE.
3003	1/1/1900	DUR+ CALLED
3019	1/1/1900	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	1/1/1900	BILLING TAXONOMY IS NOT ALLOWABLE FOR THE REVENUE CODE BILLED.
3021	1/1/1900	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	1/1/1900	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	1/1/1900	SERVICE MET REQUIREMENTS FOR THE ACA PRIMARY CARE RATE INCREASE.
3025	1/1/1900	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	1/1/1900	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.
3027	1/1/1900	DENIED. TWO OR MORE NDCS CANNOT BE BILLED ON A SINGLE DETAIL ON A PROFESSIONALCLAIM WHEN A HCPCS CODE IS BILLED.
3028	1/1/1900	DETAIL CARRIER MUST ALSO BE PRESENT IN THE HEADER.

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EOB Code	Effective Date	Description
3029	1/1/1900	CLAIM FILING VALUE IS INVALID.
3030	1/1/2014	COVERAGE LIMITED TO FEDERAL LEGEND DRUGS OR OVER-THE-COUNTER DRUGS.
3032	1/1/1900	NEWLY RELEASED DRUG, MANUAL PRIOR AUTHORIZATION IS REQUIRED
3034	1/1/1900	THE SUM OF COVERED PLUS NON-COVERED DAYS IS NOT EQUAL TO THE DATE RANGE INDICATED ON THE CLAIM.
3036	1/1/1900	A VALID ENROLLED PRESCRIBING/REFERRING/ORDERING PROVIDER IS REQUIRED AND MAY ONLY PRESCRIBE, REFER OR ORDER SERVICES WITHIN THEIR LEGAL SCOPE OF PRACTICE.
3041	1/1/1900	SUBMITTING MCO IS NOT THE ENROLLED MCO OF THE MEMBER OR THE MEMBER IS NOT ENROLLED IN MANAGED CARE ON THE DATE OF SERVICE.
3042	1/1/1995	OTHER PAYER IDENTIFIER HAS BEEN DUPLICATED
3044	1/1/1900	DENIED. MEMBER IS NO LONGER ENROLLED IN CARE4KIDS.
3045	1/1/1900	DENIED. MEMBER IS NOW ENROLLED IN CARE4KIDS.
3046	1/1/1900	DENIED. SERVICE IS NOT COVERED BY THE MEMBER'S PROGRAM.
3048	1/1/1900	MANIFESTATION DIAGNOSES CANNOT BE USED AS THE PRINCIPAL DIAGNOSIS
3049	1/1/1900	EXTERNAL CAUSE OF MORBIDITY (ECM) DIAGNOSIS CODE(S) ARE INVALID AS THE PRINCIPAL DIAGNOSIS
3050	1/1/1900	A MORE SPECIFIC DIAGNOSIS CODE IS REQUIRED FOR THIS DETAIL
3051	1/1/1900	NONSPECIFIC DIAGNOSIS CODES CANNOT BE USED
3052	1/1/1900	NONSPECIFIC ICD PROCEDURE CODES CANNOT BE USED
3053	1/1/1900	THIS DETAIL CONTAINS DATES THAT OVERLAP WITH ANOTHER DETAIL ON THE SAME CLAIM OR OF ANOTHER PAID DETAIL ON A PREVIOUS CLAIM.
3056	1/1/1900	AMBULANCE MILEAGE REQUIRES A PAID EQUIVALENT AMBULANCE BASE CODE; BASIC LIFE SUPPORT (BLS), ADVANCED LIFE SUPPORT (ALS) OR NON-EMERGENCY MEDICAL TRANSPORT (NEMT).
3100	1/1/1900	PA REQUIRED -PA MISSING OR INVALID
3101	1/1/1900	PA NUMBER NOT ON FILE
3102	1/1/1900	PA REQUIRED - AWAITING PRIOR AUTH
3103	1/1/1900	PA REQUIRED AND NOT FOUND
3104	1/1/1900	PA/MEMBER CONFLICT
3105	1/1/1900	PA/PROVIDER CONFLICT
3106	1/1/1900	PA/PROCEDURE CONFLICT
3107	1/1/1900	PA/MODIFIER CONFLICT
3108	1/1/1900	PA/TOOTH NUMBER CONFLICT
3109	1/1/1900	PA/TOOTH SURFACE CONFLICT
3110	1/1/1900	PA/REVENUE CODE CONFLICT
3111	1/1/1900	PA/DATE OF SERVICE CONFLICT
3112	1/1/1900	PA LINE ITEM IS NOT APPROVED OR HAS BEEN EXHAUSTED
3113	1/1/1900	PA IS NOT APPROVED
3114	1/1/1900	PRICING PA REQUIRED
3115	1/1/1900	INSUFFICIENT AVAILABLE PA UNITS

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EOB Code	Effective Date	Description
3116	1/1/1900	INSUFFICIENT AVAILABLE PA DOLLARS
3117	1/1/1900	INPATIENT PA NOT FOUND
3118	1/1/1900	PA PAYMENT CODE CONFLICT
3160	1/1/1900	COMPOUND CLAIMS ONLY ALLOWED WITH A PRIOR AUTHORIZATION
3161	1/1/1900	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	1/1/1900	DRUG / PA REQUIRES CLINICAL REVIEW.
3163	1/1/1900	CLAIM IS FOR A NON-PREFERRED EPINEPHRINE AUTO-INJECTION. USE GENERIC LABELER 49502 FOR PREFERRED EPINEPHRINE AUTO INJECTION.
3164	1/1/1900	MEMBERS AGE IS LESS THAN RECOMMENDED MIN AGE FOR THIS DRUG. MUST SUBMIT AGE WAIVER SIGNED BY PRESCRIBER FOR APPROVAL.
3165	1/1/1900	CIPRO HC REQ PA FOR MEMBERS AGE 9 YRS AND UP. REFER TO PDL FOR PREFERRED MEDS FOR TX OF ACUTE OTITIS EXTERNA.
3166	1/1/1900	CHANTIX 1 MG CONT MONTH PAK REQ PA IF MEMBERS AGE IS LESS THAN RECOMMENDED MINAGE 18 YRS.
3167	1/1/1900	CIPRODEX REQ PA FOR MEMBERS AGE 15 YRS AND UP. REFER TO PDL FOR PREFERRED MEDSFOR TX OF ACUTE OTITIS EXTERNA.
3168	1/1/1900	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	1/1/1900	FERTILITY TREATMENT IS NOT COVERED BY MEDICAID, HOWEVER OTHER INDICATIONS WILLBE CONSIDERED FOR COVERAGE. PRESCRIBER MAY SUBMIT A PRIOR AUTHORIZATION REQUEST.
3170	1/1/1900	AMPYRA REQUIRES CLINICAL REVIEW.
3171	1/1/1900	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	1/1/1900	BROVANA AND PERFOROMIST ARE INDICATED FOR AGE >/= 18 YEARS. MUST SUBMIT AGE WAIVER SIGNED BY PRESCRIBER FOR APPROVAL.
3173	1/1/1900	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	1/1/1900	INGREZZA REQUIRES A MANUAL PA FOR APPROVAL.
3175	1/1/1900	KESIMPTA, MAVENCLAD, MAYZENT, PONVORY AND TASCENSO ODT REQUIRE A CLINICAL REVIEW FOR APPROVAL.
3176	1/1/1900	REBATED KIT LIST REQUIRES PA. NON REBATED NOT COVD.
3177	1/1/1900	REQUESTED RX IS FOR NONPREFERRED ATRIPLA. PLEASE DISPENSE GENERIC EFAVIRENZ/EMTRICITABINE/TENOFOVIR.
3178	1/1/1900	REQUESTED RX IS FOR NONPREFERRED ATRIPLA OR GENERIC EFAVIRENZ/EMTRICITABINE/TENOFOVIR. PLEASE DISPENSE PREFERRED AUTHORIZED GENERIC EFAVIRENZ/EMTRICITABINE/TENOFOVIR LABELER CODE 00093.

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EOB Code	Effective Date	Description
3179	1/1/1900	BILL VIA MEDICAL CLAIM, PA REQUIRED FOR POS VENUE.
3180	1/1/1900	DAKLINZA, EPCLUSA, HARVONI, MAVYRET, SOVALDI, VOSEVI, AND ZEPATIER REQUIRE A CLINICAL REVIEW.
3181	1/1/1900	FASENRA SYRINGES, NUCALA VIALS, AND CINQAIR ARE NOT SELF-ADMINISTERED AND CANNOT BE BILLED THROUGH POS. PLEASE BILL THROUGH MEDICAL VENUE.
3182	1/1/1900	ORTIKOS ER REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3183	1/1/1900	CARISOPRODOL WITH CODEINE REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3184	1/1/1900	LINDANE SHAMPOO REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3185	1/1/1900	KALYDECO, ORKAMBI, SYMDEKO, AND TRIKAFTA REQUIRE A CLINICAL REVIEW FOR APPROVAL.
3186	1/1/1900	ZEPOSIA REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3187	1/1/1900	RESTASIS MULTIDOSE VIALS ARE NON-PREFERRED. PLEASE DISPENSE PREFERRED RESTASISDROPERETTES.
3188	1/1/1900	PROAIR DIGIHALER REQUIRES A CLINICAL REVIEW FOR APPROVAL.
3189	1/1/1900	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	1/1/1900	SERVICE IS NOT COVERED FOR THE DIAGNOSIS INDICATED.
3206	1/1/1900	DENIED. DIAGNOSIS CODE IS NOT ALLOWABLE.
3208	1/1/1900	DENIED. PROCEDURE BILLED NOT A COVERED SERVICE FOR DATES INDICATED.
3212	1/1/1900	PRESCRIBER ID AND QUALIFIER DO NOT MATCH
3268	1/1/1900	MEMBER ENROLLED IN MEDICARE PART D. CLAIM IS EXCLUDED FROM DRUG REBATE INVOICING.
3301	1/1/1900	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	1/1/1900	DELAWARE MEDICAID DOES NOT COVER ANY SERVICES RELATING SOLELY TO THE TREATMENTOF INFERTILITY.
3303	1/1/1900	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	1/1/1900	YOU ARE BILLING A "SICK VISIT CODE" WITH GYNECOLOGICAL EXAM DIAGNOSIS. RESUBMITWITH SUPPORTING DOCUMENTATION OR REBILL USING ANNUAL GYN EXAM CODE.
3305	1/1/1900	RECIPIENT IS ELIGIBLE FOR EMERG SVCS/LABOR/DELIVERY ONLY. STERILIZATION IS NOT A COVERED SVC. REBILL FOR CHARGES ASSOCIATED WITH THE DELIVERY ONLY.
3306	1/1/1900	DENIED. MEDICARE ALLOWED AMOUNT REQUIRED.
3308	1/1/1900	DENIED. FROM DATE OF SERVICE/DATE FILLED IS MISSING/INVALID.
3314	1/1/1900	DENIED. DETAIL DATES ARE NOT WITHIN STATEMENT COVERED PERIOD.
3315	1/1/1900	A NURSING HOME ACCOMMODATION CLAIM HAS ALREADY BEEN PAID FOR THE CALENDAR MONTHBILLED. PLEASE ADJUST AS NECESSARY.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
3316	1/1/1900	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	1/1/1900	CHIROPRACTIC MANIPULATIONS LIMITED TO 20 PER YEAR.
3318	1/1/1900	NOT USED - DMAP COVERS A MAXIMUM OF 3 DOSES.
3319	1/1/1900	DSCYF BUNDLED RATE AND RTC STAY MAY NOT BE BILLED FOR THE FULL MONTH.
3321	1/1/1900	CUMULATIVE EARLY REFILL LIMITED TO 4 EVERY 120 DAYS.
3323	1/1/1900	MEDICAID COVERS NINE PREVENTIVE MEDICINE SERVICES FOR THE HEALTHY INDIVIDUAL UNDER AGE ONE. PAYMENT HAS ALREADY BEEN MADE FOR NINE VISITS.
3333	1/1/1900	CCO ENCOUNTER CLAIM IS DENIED.
3335	1/1/1900	ADMIT DIAGNOSIS IS INVALID FOR THE DATE(S) OF SERVICE
3342	1/1/1900	Inpatient Per Diem Rate Not Found
3351	1/1/1900	SERVICE NOT COVERED FOR LTC MEMBER
3352	1/1/1900	OTC DRUG NOT COVERED FOR LTC MEMBER
3358	1/1/1900	ALLOWED AMOUNT EXCEEDS THRESHOLD
3368	1/1/1900	DRG CODE MISSING/INVALID ON ENCOUNTER CLAIM
3375	1/1/1900	FPW SERVICES ARE NON-COVERED WHEN CLAIM CONTAINS NON-FPW DIAGNOSIS CODES.
3385	1/1/1900	POS 21 22 23 NOT PAYABLE FOR FQHC/RHC PROVIDERS
3386	1/1/1900	MNTL HLTH MODIFIER HW RSTRN FOR TAXONOMY
3390	1/1/1900	PROVIDER NOT VFC ATTESTED FOR VACCINE OR ADMIN CODES
3391	1/1/1900	ROUTINE CIRCUMCISION NOT COVERED
3400	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	MEDICAID COVERS ONE ROUTINE GYNECOLOGICAL EVALUATION FOR THE HEALTHY INDIVIDUALEACH CALENDAR YEAR. PAYMENT HAS ALREADY BEEN MADE FOR THIS CALENDAR YEAR.
3411	1/1/1900	DIAGNOSIS CODE NOT SPECIFIC
3452	1/1/1900	DISPENSE THE PREFERRED BRAND RATHER THAN THE NON-PREFERRED GENERIC. SEE PREFERRED DRUG LIST (PDL) AT HTTP://WWW.MEDICAID.MS.GOV/
3459	1/1/1900	HCBS NOT COVERED WHEN MEMBER IS IN A NURSING HOME
3460	1/1/1900	SERVICES NOT COVERED FOR LOCKIN MEMBER

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
3461	1/1/1900	CSP NOT ALLOWED FOR WED WIL WID WTB SED LOCKINS
3462	1/1/1900	THE BILLING AND RENDERING PROVIDER IS REQUIRED TO BE THE SAME PROVIDER.
3500	1/1/1900	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	1/1/1900	MORE THAN 12 PHARMACOLOGIC MANAGEMENT SERVICES IN A STATE FISCAL YEAR REQUIRE PRIOR AUTHORIZATION FOR RECIPIENTS ENROLLED IN DIAMOND STATE PARTNERS.
3502	1/1/1900	MORE THAN FOUR BITEWING FILMS WITHIN SIX MONTHS REQUIRE ADDITIONAL DOCUMENTATION. RESUBMIT WITH NOTES TO DOCUMENT THE NEED FOR ADDITIONAL BITEWING FILMS.
3503	1/1/1900	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	1/1/1900	ONE NEW PATIENT SERVICE PER 3 YEARS PER PROVIDER.
3505	1/1/1900	PART OR ALL OF THE UNITS BILLED EXCEED MAXIMUM ALLOWABLE LIMITS.
3507	1/1/1900	PROCEDURE IS ALLOWED ONE TIME IN 6 MONTHS AFTER COMPLETION OF PERIDONTAL SCALING. MUST NOT BE BILLED WITHIN 3 MONTHS OF PROPHYLAXIS.
3509	1/1/1900	PROPER RESOLUTION OF THIS CLAIM REQUIRES THE ASSOCIATED ER VISIT NOTES OR INPATIENT HOSPITAL DISCHARGE SUMMARY. PLEASE RESUBMIT WITH THIS DOCUMENTATION.
3580	1/1/1900	TPL - HMS LONG TERM CARE AUDITS (LTC)
3581	1/1/1900	TPL - HMS CREDIT BALANCE AUDITS (CBA)
3582	1/1/1900	TPL - HMS COMMERCIAL DISALLOWANCE
3583	1/1/1900	TPL - HMS MEDICARE DISALLOWANCE
3601	1/1/1900	PULP TREATMENT IS DISALLOWED WHEN ENDODONTIC TREATMENT IS COMPLETED ON SAME DAY.
3602	1/1/1900	QUANTITY LIMITS FOR MEDICATION CLASS HAVE BEEN EXCEEDED.
3603	1/1/1900	SERVICE COVERED ONE TIME IN TWO YEARS. YOU OR ANOTHER PROVIDER HAVE BEEN REIMBURSED FOR THIS SERVICE.
3604	1/1/1900	SERVICE IS LIMITED TO ONE TIME IN 5 YEARS. YOU OR ANOTHER PROVIDER HAVE BEEN PAID FOR THIS SERVICE.
3605	1/1/1900	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	1/1/1900	SERVICE LIMITED TO ONE PER CALENDAR YEAR. PAYMENT HAS ALREADY BEEN MADE TO YOUOR ANOTHER PROVIDER FOR THIS CALENDAR YEAR.
3610	1/1/1900	SERVICE LIMITED TO ONE PER PROVIDER PER DAY.
3732	1/1/1900	DRG RESTRICTION ON REV CODE CVG RULE.
3801	1/1/1900	SERVICE ROUTINELY COVERED ONCE PER 365 DAYS. PAYMENT HAS ALREADY BEEN MADE. FORREVIEW OF MEDICAL NECESSITY RESUBMIT WITH FULL DOCUMENTATION.
3802	1/1/1900	SERVICE ROUTINELY COVERED ONCE PER SIX MONTHS. PAYMENT HAS ALREADY BEEN MADE TOYOU OR ANOTHER PROVIDER.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
3803	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	THE DATES OF SERVICE ON THIS CLAIM OVERLAP THE DATES OF SERVICE ON A CLAIM PREVIOUSLY SUBMITTED. ADJUST AS NECESSARY.
3812	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	THERAPEUTIC DUPLICATION.
3816	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	THIS SERVICE IS COVERED ONE TIME IN 3 YEARS. THE FREQUENCY LIMIT HAS BEEN EXHAUSTED.
3820	1/1/1900	UNITS BILLED EXCEED MAX ALLOWED PER DAY.
3821	1/1/1900	YOU ARE BILLING A COMPLETE INTRAORAL RADIOGRAPHIC SERIES WITHIN 30 DAYS OF PANORAMIC, PERIAPICAL OR BITEWING X-RAY.
3822	1/1/1900	YOU ARE BILLING AN ANCILLARY PROCEDURE WITHOUT A SURGICAL PROCEDURE ON THE SAMEDAY. THIS CLAIM WILL NOT BE PAID.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
3823	1/1/1900	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	1/1/1900	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	1/1/1900	YOU ARE BILLING FOR MULTIPLE SURGICAL PROCEDURES ON THE SAME DAY. AN OPERATIVEREPORT IS REQUIRED IN ORDER TO DETERMINE THE PROPER PAYMENT.
3826	1/1/1900	YOUR CLAIM HAS EXCEEDED AN ALLOWED AMOUNT OF $500 . PLEASE VERIFY THE QUANTITYBILLED. IF CORRECT, PLEASE CONTACT HPES FOR PRIOR AUTHORIZATION.
3870	1/1/1900	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	1/1/1900	THE PROCEDURE BILLED IS RESTRICTED BY LOCKIN PLAN
3892	1/1/1900	THE REVENUE NEEDS TO BE BILLED WITH ANOTHER REVENUE ON CLAIM.
3893	1/1/1900	THE PROCEDURE CODE REQUIRES AN APPROPRIATE CORRESPONDING REVENUE CODE ON THE SAME CLAIM.
3895	1/1/1900	THE PROCEDURE CODE REQUIRES AN APPROPRIATE CORRESPONDING REVENUE CODE ON THE SAME DETAIL.
3897	1/1/1900	THE REVENUE CODE BILLED HAS QUANTITY RESTRICTIONS
3899	1/1/1900	THE PROCEDURE CODE BILLED WITH THE REVENUE CODE IS INVALID OR MISSING.
3990	1/1/1900	TPL RESTRICTION ON PROC CVG RULE
3991	1/1/1900	NO CVG RULE FOR PROC VIA PROC GRP
3992	1/1/1900	TYPE OF BILL RESTRICTION ON REV CODE CVG RULE
3993	1/1/1900	TPL RESTRICTION ON REV CODE CVG RULE
3994	1/1/1900	ICD PROCEDURE NOT COVERED FOR MEMBER'S BENEFIT PLAN.
4002	1/1/1900	MEMBER'S BENEFIT PACKAGE DOES NOT INCLUDE THIS MEDICATION.
4003	1/1/1900	PRODUCT NOT COVERED. (IF MEDICAL SUPPLY, SUBMIT PROFESSIONAL CLAIM.)
4004	1/1/1900	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	1/1/1900	IF AGE < 21, PRESCRIBER MAY SUBMIT PA MEDICAL NECESSITY REQUEST FOR EPSDT ELIGIBLE MEMBER.
4012	1/1/1900	Newly Released Drug. Contact the Gainwell Technologies Pharmacy Helpdesk for billing options.
4014	1/1/1900	NO PRICING ON FILE
4015	1/1/1900	NO PATIENT LIABILITY FOR DOS - RECYCLE
4016	1/1/1900	NO PATIENT LIABILITY FOR DOS - CONTACT REGIONAL OFFICE
4022	1/1/1900	NO DRUG COVERAGE UNDER MEMBER'S QUALIFIED MEDICARE BENEFICIARY (QMB) BENEFIT PLAN.
4032	1/1/1900	NO DRUG COVERAGE UNDER MEMBER'S SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB) BENEFIT PLAN.
4052	1/1/1900	ADMIT DIAGNOSIS CODE IS NOT ON FILE.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
4062	1/1/1900	PRINCIPAL ICD PROCEDURE CODE IS NOT COVERED
4063	1/1/1900	NON-COVERED ICD PROCS (1ST ICD PROC)
4064	1/1/1900	NON-COVERED ICD PROCS (ICD PROCS 2-24)
4074	1/1/1900	LABS ONLY ALLOW POS 11 22 23 32 50 51 71 72 81.
4075	1/1/1900	EPSDT SERVICES REQUIRE AGREEMENT OR ATTESTATION
4076	1/1/1900	THE COMBINED SUBMITTED UNITS FOR THE VACCINE ADMINISTRATION SERVICES MUST EQUALTHE COMBINED SUBMITTED UNITS FOR THE VACCINE SERVICES.
4080	1/1/1900	MEMBER EXCEEDS AGE FOR PEDIATRIC LTC HOSP
4082	1/1/1900	MEMBER DOES NOT MEET THE AGE RESTRICTION FOR INPATIENT/PRTF PSYCHIATRIC SERVICES.
4083	1/1/1900	PATIENT'S STATUS IS DISCHARGED.
4086	1/1/1900	WEEKEND PRTF ADMISSION NOT ALLOWED
4092	1/1/1900	CONSENT NOT APPROVED-STERIL, ABORTION AND HYST
4096	1/1/1900	MDC NOT ON FILE
4099	1/1/1900	DRG NOT ON FILE
4100	1/1/1900	DRG RATE RECORD NOT FOUND
4102	1/1/1900	HOSPICE LOCK-IN COUNTY NOT FOUND
4104	1/1/1900	PROVIDER DRG RATE RECORD NOT FOUND
4105	1/1/1900	UNABLE TO ASSIGN MCC FOR DRG PRICING
4106	1/1/1900	INVALID DRG INTERIM STAY PER DIEM
4107	1/1/1900	INVALID DRG COST OUTLIER PRICING DATA
4108	1/1/1900	COVERED DAYS ARE LESS THAN OR EQUAL TO INTERIM BILL THRESHOLD.
4109	1/1/1900	OUTPATIENT PER DIEM RATE NOT FOUND
4110	1/1/1900	DRG LONG STAY THRESHOLD WITHOUT PA
4140	1/1/1900	ANNUAL PHYSICAL EXAMS ARE NOT COVERED FOR FIRST YEAR
4141	1/1/1900	MEMBER'S DATE OF DEATH IS NOT ON FILE. DATE OF DEATH REQUIRED FOR REVENUE BILLED.
4142	1/1/1900	HOSPICE PATIENT STATUS IS EXPIRED BUT MEMBER'S DATE OF DEATH IS NOT ON FILE. SERVICE INTENSITY ADD-ON (SIA) NOT APPLIED.
4144	1/1/1900	HOSPICE SERVICE INTENSITY ADD-ON (SIA) NOT ALLOWED. SIA SERVICES NOT PERFORMEDWITHIN 7 DAYS OF THE MEMBER'S DATE OF DEATH ON FILE.
4145	1/1/1900	HOSPICE NF UNITS GREATER THAN TOTAL DAYS
4146	1/1/1900	MEMBER'S HOSPICE LOCK-IN COUNTY NOT REIMBURSABLE. CONTACT ALLIANT TO UPDATE THEHOSPICE PRECERTIFICATION FORM WITH MEMBER'S COUNTY WHERE HOSPICE SERVICES AREBEING PERFORMED.
4148	1/1/1900	PATIENT DISCHARGE STATUS DOES NOT MEET BILLING RESTRICTIONS FOR THE REVENUE CODE BILLED.
4153	1/1/1900	ADMIT TYPE RESTRICTED FOR SERVICES BILLED.
4154	1/1/1900	DRG COVERED DAYS RESTRICTED FOR SERVICES BILLED.
4155	1/1/1900	SERVICE NOT COVERED WHEN BILLED BY AN OUTPATIENT HOSPITAL
4159	1/1/1900	THE SERVICE IS NOT REIMBURSABLE FOR THE PROVIDER'S CONTRACT.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
4160	1/1/1900	DETAIL FDOS/TDOS SPANS MORE THAN ONE DAY
4161	1/1/1900	PROCEDURE NOT REIMBURSEABLE FOR BILLING PROVIDER
4162	1/1/1900	REVENUE CODE NOT REIMBURSEABLE FOR BILLING PROVIDER
4189	1/1/1900	PROVIDER UCC RATE NOT FOUND
4190	1/1/1900	PROCEDURE MAX FEE RATE NOT FOUND
4191	1/1/1900	PROCEDURE/MODIFIER MAX FEE RATE NOT FOUND
4192	1/1/1900	ANESTHESIA RATE NOT FOUND
4193	1/1/1900	PROVIDER CLINIC RATE NOT FOUND
4194	1/1/1900	LTC Segment Not Found for Hospice Member - Recycle
4195	1/1/1900	LTC Segment Not Found for Hospice Member
4196	1/1/1900	Hospice LTC Per Diem Rate Not Found
4197	1/1/1900	LTC Per Diem Rate Not Found
4198	1/1/1900	PROVIDER REVENUE RATE NOT FOUND
4199	1/1/1900	REVENUE RATE NOT FOUND
4230	1/1/1900	MEDICARE DEDUCTIBLE SUBMITTED ON THE CLAIM IS GREATER THAN THE ANNUAL MEDICAREDEDUCTIBLE
4260	1/1/1900	PROC CODE GROUP RESTRICTION ON PROC CVG RULE
4261	1/1/1900	REV CODE GROUP RESTRICTION ON REV CVG RULE
4262	1/1/1900	LOCKIN REQUIRED FOR REVENUE CODE BILLING RULE
4264	1/1/1900	MEMBER LOCKIN PLAN RSTCN ON NDC CVG RULE
4265	1/1/1900	MEMBER LOCKIN PLAN RSTCN ON PROC CVG RULE
4267	1/1/1900	BILLING PROVIDER TAXONOMY RSTCN ON REV CVG RULE
4268	1/1/1900	MEMBER LOCKIN PLAN RSTCN ON REV CVG RULE
4346	1/1/1900	MEDICAL DEVICES NOT COVERED
4373	1/1/1900	NONPREFERRED GENERIC/ NO PA REQUIRED FOR PREFERRED BRAND
4502	1/1/1900	MEDICARE EOMB IS MISSING OR DOES NOT MATCH THE SERVICES ON THE CLAIM. RESUBMITTHE CLAIM WITH THE MEDICARE EOMB ATTACHED.
4503	1/1/1900	MEMBER IS ENROLLED IN MEDICARE PART C ON THE DATE(S) OF SERVICE.
4504	1/1/1900	MEDICARE EOMB INFORMATION IS MISSING AT THE CLAIM DETAIL. RESUBMIT THE CLAIM WITH THE MEDICARE EOMB INFO SUBMITTED AT THE DETAIL.
4512	1/1/1900	MEDICARE EOMB HAS MORE DETAILS THAN ON CLAIM OR MEMBERS LISTED DO NOT MATCH. CLAIM HAS MORE DETAILS THAN ON MEDICARE EOMB. CORRECT AND RESUBMIT THE CLAIM TOMATCH THE NUMBER OF DETAILS ON THE MEDICARE EOMB.
4522	1/1/1900	MEDICARE EOMB PROCEDURE/REVENUE CODE/DOS, MEDICARE PAID DATE OR MEMBER'S NAME DO NOT MATCH WHAT WAS SUBMITTED ON THE CLAIM. CORRECT AND RESUBMIT THE CLAIM WITH THE CORRECT MEDICARE INFORMATION AND EOMB.
4532	1/1/1900	MEDICARE EOMB SUBMITTED AMOUNTS ON THE CLAIM DO NOT MATCH THE SUBMITTED MEDICARE EOMB SUCH AS COINSURANCE, DEDUCTIBLE, COPAY OR MEDICARE PAID. CORRECT AND RESUBMIT THE CLAIM WITH THE CORRECT MEDICARE INFORMATION AND EOMB.
4600	1/1/1900	PRIMARY DIAGNOSIS AND AGE CONFLICT

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
4602	1/1/1900	FIRST DIAGNOSIS/AGE CONFLICT
4603	1/1/1900	SECOND DIAGNOSIS/AGE CONFLICT
4604	1/1/1900	THIRD DIAGNOSIS/AGE CONFLICT
4605	1/1/1900	FOURTH DIAGNOSIS/AGE CONFLICT
4606	1/1/1900	FIFTH DIAGNOSIS/AGE CONFLICT
4607	1/1/1900	DIAGNOSIS CODE 6-24 AGE CONFLICT
4608	1/1/1900	NO GENDER MATCH FOR DIAGNOSIS CODE
4610	1/1/1900	FIRST DIAGNOSIS/GENDER CONFLICT
4611	1/1/1900	SECOND DIAGNOSIS/GENDER CONFLICT
4612	1/1/1900	THIRD DIAGNOSIS/GENDER CONFLICT
4613	1/1/1900	FOURTH DIAGNOSIS/GENDER CONFLICT
4614	1/1/1900	FIFTH DIAGNOSIS/GENDER CONFLICT
4615	1/1/1900	DIAGNOSIS CODE 6 -24 GENDER CONFLICT
4616	1/1/1900	PRINCIPLE ICD SURGICAL PROCEDURE CODE/GENER CNFL
4617	1/1/1900	1ST ICD SURGICAL PROCEDURE/GENDER CONFLICT
4618	1/1/1900	ICD SURGICAL PROCEDURE CODES IN ONE OR MORE POSITIONS 3-24 HAS A GENDER CONFLICT
4619	1/1/1900	ICD9 CODES WITH DATES OF SERVICE AFTER ICD10 CUTOVER
5000	1/1/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5001	1/1/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM
5002	1/1/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5003	1/1/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5004	1/1/2014	THIS DETAIL IS BEING PAID AND THE SAME DRUG WITH OVERLAPPING DATES IS BEING RECOUPED ON A MEDICAL CLAIM.
5005	1/1/1900	INPATIENT SERVICES PERFORMED THREE DAYS AFTER OUTPATIENT DATE OF SERVICE
5006	1/1/2014	OUTPATIENT SERVICES PERFORMED THREE DAYS PRIOR TO INPATIENT ADMISSION.
5007	1/1/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5008	1/1/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5009	1/1/1900	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	1/1/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5011	1/1/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5013	1/1/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5014	1/1/1900	A PHARMACY CLAIM WITH THE SAME DRUG IS PAID WITH OVERLAPPING DATES OF SERVICE.
5020	1/1/2014	THIS IS A SUSPECT DUPLICATE OF ANOTHER CLAIM.
5021	1/1/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5022	1/1/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5023	1/1/1900	THIS IS A DUPLICATE OF ANOTHER CLAIM FILLED BY A DIFFERENT PROVIDER.
5024	1/1/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5026	1/1/2014	SUSPECT WAIVER SERVICE DURING INPATIENT STAY.
5027	1/1/1900	THE INPATIENT SERVICE IS PAID AND A WAIVER SERVICE FOR OVERLAPPING DATES OF SERVICE IS BEING RECOUPED.
5028	1/1/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5030	1/1/2014	THIS IS A SUSPECT DUPLICATE OF ANOTHER CLAIM.
5031	1/1/1900	THIS IS A SUSPECT DUPLICATE OF ANOTHER CLAIM.
5032	1/1/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5033	1/1/1900	THIS IS A SUSPECT DUPLICATE OF ANOTHER CLAIM.
5040	1/1/1900	Leave Days are greater than Total Days Billed
5050	1/1/2014	A SURGICAL PROCEDURE CODE FOR THE SAME PHYSICIAN FOR THE SAME DATE OF SERVICE HAS BEEN PREVIOUSLY PAID.
5056	1/1/2014	THIS IS A DUPLICATE OF ANOTHER CLAIM.
5100	1/1/1900	Encounters vs Encounters Exact Dupe
5102	1/1/1900	CHIP Encounters vs CHIP Encounters Exact Dupe
5104	1/1/1900	NET Encounter Transportation Exact Dupe
5110	1/1/1900	Pharmacy vs Pharmacy Exact Dupe
5111	1/1/1900	Pharmacy vs Pharmacy Suspect Dupe
5115	1/1/1900	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	1/1/1900	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	1/1/1900	ROUTINE POST-OPERATIVE MEDICAL VISITS ARE NOT SEPARATELY PAYABLE.
5201	1/1/1900	SURGICAL SERVICES AND ROUTINE PREOPERATIVE MEDICAL VISITS ARE NOT SEPARATELY PAYABLE. A PREVIOUSLY PAID ROUTINE PREOPERATIVE MEDICAL VISIT IS BEING RECOUPED.
5202	1/1/1900	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	1/1/1900	PRIOR TO 07/01/2019 PHYSICIAN OFFICE VISITS LIMITED TO 12 PER STATE FISCAL YEAR.
5385	1/1/1900	PRIOR TO 07/01/2019 PSYCHIATRIC OFFICE VISITS LIMITED TO 12 PER STATE FISCAL YEAR
5500	1/1/2014	FAMILY PLANNING WAIVER OUTPATIENT OFFICE VISITS LIMITED TO 4 PER CALENDAR YEAR
5501	1/1/1900	DENTAL SERVICES ARE LIMITED TO $2500 PER FISCAL YEAR.
5502	1/1/2014	NURSING HOME LEAVE OF ABSENCE DAYS LIMITED TO 58 DAYS PER STATE FISCAL YEAR
5504	1/1/2014	DENTAL ORAL EXAMS ARE LIMITED TO TWO PER STATE FISCAL YEAR.
5505	1/1/1900	INTERMEDIATE CARE FACILITY LEAVE OF ABSENCE DAYS LIMITED TO 90 DAYS PER STATE FISCAL YEAR
5506	1/1/2014	PSYCHIATRIC RESIDENTIAL TREATMENT CENTER LEAVE OF ABSENCE DAYS LIMITED TO 90 DAYS PER STATE FISCAL YEAR
5507	1/1/1900	PERIODIC ORAL EVALUATION IS LIMITED TO ONE PER SIX MONTHS.

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EOB Code	Effective Date	Description
5508	1/1/1900	DENTAL PROCEDURE D0150 LIMITED TO 1 PER 36 MONTHS BY SAME PROVIDER.
5509	1/1/1900	CHIROPRACTIC SERVICES LIMITED TO $700 PER STATE FISCAL YEAR.
5510	1/1/1900	DENTAL ORAL EVALUATIONS ARE LIMITED TO 4 PER STATE FISCAL YEAR.
5511	1/1/1900	PSYCHIATRIC THERAPEUTIC LEAVE DAYS LIMITED TO 18 PER STATE FISCAL YEAR.
5512	1/1/2014	PERIODONTAL SERVICES LIMITED TO ONE PER AREA OF ORAL CAVITY PER 2 ROLLING YEARS.
5513	1/1/1900	PROPHYLAXIS SERVICE LIMITED TO TWO PER STATE FISCAL YEAR
5514	1/1/2014	FLUORIDE SERVICE LIMITED TO TWO PER STATE FISCAL YEAR.
5515	1/1/1900	Eye Refractions are limited to 2 per state fiscal year for members under 21.
5516	1/1/2014	Eyeglass Lens Limited to 4 per State fiscal year for members under 21.
5517	1/1/1900	EYEGLASS FRAMES LIMITED TO 2 PER STATE FISCAL YEAR
5518	1/1/2014	HOME HEALTH DAYS LIMITED TO 36 DAYS PER STATE FISCAL YEAR.
5519	1/1/1900	Eye refraction limited to 1 per 5 years for members 21 & older.
5520	1/1/2014	PHYSICIAN OFFICE VISITS LIMITED TO 16 PER STATE FISCAL YEAR.
5524	1/1/2014	PHYSICIAN LONG TERM CARE VISITS LIMITED TO 36 PER STATE FISCAL YEAR.
5525	1/1/1900	HEARING AID SERVICE LIMIT EXCEEDED
5526	1/1/2014	Eyeglass Lens Limited to 2 per 5 years for members 21 & older.
5527	1/1/1900	PHARMACY DISEASE MANAGEMENT COUNSELING SERVICES LIMITED TO 12 SESSIONS PER STATE FISCAL YEAR
5532	1/1/2014	MENTAL HEALTH ASSESSMENT OR EVALUATION SERVICE LIMITED TO 4 PER STATE FISCAL YEAR.
5533	1/1/1900	MENTAL HEALTH ASSERTIVE COMMUNITY TREATMENT SERVICE LIMITED TO 1600 PER YEAR
5534	1/1/2014	MENTAL HEALTH CRISIS RESPONSE SERVICE LIMITED TO 224 PER STATE FISCAL YEAR.
5535	1/1/1900	MENTAL HEALTH COMMUNITY SUPPORT SERVICE LIMITED TO 400 PER STATE FISCAL YEAR
5536	1/1/2014	MENTAL HEALTH PEER SUPPORT SERVICE LIMITED TO 200 PER STATE FISCAL YEAR.
5537	1/1/1900	MENTAL HEALTH WRAPAROUND SERVICE LIMITED TO 200 PER STATE FISCAL YEAR
5538	1/1/2014	MENTAL HEALTH PLAN DEVELOPMENT SERVICE LIMITED TO 4 PER STATE FISCAL YEAR.
5539	1/1/1900	MENTAL HEALTH PSYCHOLOGICAL EVALUATION SERVICES LIMITED TO 8 PER STATE FISCAL YEAR
5540	1/1/2014	MENTAL HEALTH CRISIS RESIDENTIAL SERVICE LIMITED TO 60 PER STATE FISCAL YEAR.
5541	1/1/1900	MENTAL HEALTH INTENSIVE OUTPATIENT PSYCHIATRIC SERVICE LIMITED TO 270 PER STATEFISCAL YEAR
5542	1/1/2014	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	1/1/1900	RESPITE WAIVER CARE SERVICES LIMITED TO 30 DAYS PER STAY
5544	1/1/2014	HOME AND COMMUNITY BASED SERVICE - RESPITE SERVICE LIMITED TO 240 UNITS PER CALENDAR MONTH.
5545	1/1/1900	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	1/1/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE.

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EOB Code	Effective Date	Description
5551	1/1/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE.
5552	1/1/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE.
5553	1/1/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE.
5557	1/1/1900	EYE EXAMS LIMITED TO 1 PER STATE FISCAL YEAR FOR MEMBERS 21 & OLDER.
5559	1/1/1900	ALCOHOL WIPES BOXES ARE LIMITED TO 2 PER MONTH
5560	1/1/2014	URINE TEST AND REAGANT STRIPS/TABLETS ARE LIMITED TO 1 PER MONTH.
5561	1/1/1900	BLOOD GLUCOSE TEST AND REAGANT STRIPS ARE LIMITED TO 4 PER MONTH
5562	1/1/2014	BLOOD GLUCOSE TESTING CALIBRATOR IS LIMITED TO 1 PER MONTH.
5563	1/1/1900	SPRING-POWERED LANCETS LIMITED TO 1 PER MONTH
5564	1/1/2014	LANCETS LIMITED TO 2 PER MONTH.
5566	1/1/2014	Eyeglass Frames Limit 1 per 5 years - 21 & older.
5567	1/1/1900	ESRD SERVICE LIMITED TO ONE PER CALENDAR MONTH
5569	1/1/1900	ANTIGEN SERVICES LIMITED TO 2 CLAIMS PER 45 DAYS
5570	1/1/2014	ROUTINE FOOT CARE WITH SYSTEMIC CONDITIONS LIMITED TO ONCE PER 60 DAYS
5571	1/1/1900	CARDIOVASCULAR DEVICE MONITORING SERVICES LIMITED TO ONCE PER 30 DAYS
5572	1/1/2014	CARDIOVASCULAR DEVICE MONITORING SERVICES LIMITED TO ONCE PER 90 DAYS
5575	1/1/1900	VISION SERVICE LIMITED TO 2 PER DATE OF SERVICE
5576	1/1/2014	SERVICES ARE LIMITED TO FIVE PER DAY.
5577	1/1/2014	CHOCTAW VISION E&M SERVICES ARE LIMITED TO ONE PER DAY.
5578	1/1/2014	CORE SERVICE ENCOUNTERS ARE LIMITED TO ONE PER DATE OF SERVICE.
5579	1/1/1900	INPATIENT CONSULTATIONS LIMITED TO ONE PER PROVIDER PER DAY
5580	1/1/2014	FRAMES LIMITED TO ONCE PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY.
5581	1/1/1900	CUSTOMER IS ALLOWED ONLY FIVE REFILLS PER PRESCRIPTION NUMBER
5582	1/1/2014	HOSPICE ROOM & BOARD SERVICES LIMITED TO ONE PER DAY PER CALENDAR MONTH
5583	1/1/1900	HOSPITAL VISITS LIMITED TO TWO PER DAY
5584	1/1/2014	HOSPITAL VISIT LIMITED TO ONE PER DAY
5585	1/1/1900	SEALANT LIMITED TO 1 PER TOOTH PER 5 ROLLING YEARS
5586	1/1/2014	DENTAL FULL MOUTH X-RAYS LIMITED TO ONE PER ROLLING 2 YEARS
5587	1/1/1900	INCONTINENT GARMENTS LIMITED TO 6 PER DAY.
5588	1/1/2014	ROOT CANAL LIMITED TO ONCE PER LIFETIME PER TOOTH.
5589	1/1/1900	DENTAL FILMS LIMITED TO 6 PER DAY
5590	1/1/2014	PRIMARY PULPOTOMY LIMITED TO 1 PER TOOTH PER LIFETIME.
5591	1/1/1900	DENTAL SCREENINGS AND EXAMS ARE LIMITED TO ONE PER DATE OF SERVICE PER PROVIDER
5592	1/1/2014	ORTHODONTIC SERVICES ARE LIMITED TO $4200 DURING THE MEMBER?S LIFETIME.
5593	1/1/1900	RESPITE CARE SERVICE T1005 LIMITED TO ONCE PER 365 DAYS
5594	1/1/2014	OFFICE VISITS ARE LIMITED TO ONE PER DAY PER PROVIDER .
5595	1/1/1900	SERVICE LIMITED TO ONCE PER LIFETIME
5596	1/1/2014	DME RENTAL LIMITED TO ONE PER CALENDAR MONTH
5597	1/1/1900	Eye Exams Limit 2 per SFY - Under 21

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5598	1/1/2014	CASE MANAGEMENT FEE SERVICES LIMITED TO ONCE PER CALENDAR MONTH
5599	1/1/1900	SEDATIVE HYPNOTICS ARE LIMITED TO 2 PER 365 DAYS.
5600	1/1/2014	POST-PARTUM VISITS LIMITED TO 2 PER 9 MONTHS.
5601	1/1/1900	Targeted Case Management Service limited to 1 per calendar month.
5602	1/1/2014	SONOGRAM SERVICES LIMITED TO 3 PER 9 MONTHS.
5603	1/1/1900	THERAPY SERVICES ARE LIMITED TO 1 PER CALENDAR MONTH
5604	1/1/2014	NEWBORN VISITS ARE LIMITED TO 1 PER 9 MONTHS.
5605	1/1/1900	NURTEC ODT LIMITED TO 1 BOX (8 TABLETS) PER 22 DAYS. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE CLINICAL PA REQUEST IF GREATER QTY NEEDED.
5606	1/1/2014	UBRELVY LIMITED TO 16 TABLETS PER 22 DAYS. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE CLINICAL PA REQUEST IF GREATER QTY NEEDED.
5607	1/1/1900	FAMILY THERAPY SERVICE LIMITED TO 1 PER DAY
5608	1/1/2014	GROUP THERAPY SERVICES LIMITED TO 1 PER DAY.
5609	1/1/1900	CASE MANAGEMENT VISITS ARE LIMITED TO 1 PER DAY
5611	1/1/1900	FLUORIDE SERVICES ALLOWED ONCE IN A 5 MONTH PERIOD
5613	1/1/1900	LIMIT DENTAL PROCEDURES D0145 (ORAL EVALUATION, PT < 3YRS) OR
D1120 (PROPHYLAXIS - CHILD) TO 1 UNIT EACH PER 5 MONTHS.		
5614	1/1/2014	T2022 LIMITED TO 1 PER MONTH
5615	1/1/1900	H2011 LIMITED TO 32 UNITS PER DAY
5616	1/1/2014	SERVICES LIMITED TO 260 UNITS PER 180 DAYS
5617	1/1/1900	SERVICES LIMITED TO 300 UNITS PER 30 DAYS
5618	1/1/2014	SERVICES LIMITED TO 300 UNITS PER 210 DAYS.
5619	1/1/1900	PROCEDURES G0396 AND G0397 LIMITED TO 1 PER 8 MONTHS
5620	1/1/2014	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	1/1/1900	ZOLPIMIST CANISTERS LIMITED TO 1 PER 25 DAYS
5622	1/1/2014	FEMALE BENEFICIARIES ARE LIMITED TO 1 CANISTER OF ZOLPIMIST PER 51 DAYS.
5623	1/1/1900	TRIAZOLAM IS LIMITED TO 10 CUMULATIVE UNITS IN THE PAST 25 DAYS. QUANTITY ON CLAIM PLUS PRESCRIPTION HISTORY EXCEEDS THIS AMOUNT
5624	1/1/2014	TRIAZOLAM IS LIMITED TO A CUMMULATIVE DAYS SUPPLY OF 60 UNITS PER 365 DAYS. QUANTITY ON CLAIM PLUS PRESCRIPTION HISTORY EXCEEDS THIS AMOUNT.
5625	1/1/1900	SEDATIVE HYPNOTICS ARE LIMITED TO 31 CUMULATIVE TOTAL UNITS IN 25 DAYS. QUANTITY ON THE INCOMING CLAIM PLUS PRESCRIPTION HISTORY EXCEEDS THIS AMOUNT
5628	1/1/1900	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.

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EOB Code	Effective Date	Description
5629	1/1/1900	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.
5630	1/1/2014	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	1/1/2014	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	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR DYNAVEL XR, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5639	1/1/1900	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	1/1/2014	NUMBER OF REFILLS EXCEEDS ALLOWED AMOUNT FOR THIS RX NUMBER
5641	1/1/1900	REFILL LIMIT EXCEEDED FOR PRESCRIPTION NUMBER
5643	1/1/1900	SUBMITTED UNITS EXCEEDS MAX ALLOWED FOR CALENDAR MONTH. PRESCRIBER MAY SUBMIT PA REQUEST FOR GREATER QUANTITY
5644	1/1/2014	HOME AND COMMUNITY BASED SERVICE - RESPITE SERVICE LIMITED TO 96 UNITS PER DAY
5646	1/1/1900	ADULT DAY CARE SERVICES LIMITED TO 16 PER DAY.
5648	1/1/1900	PSYCHOSOCIAL REHABILITATION SERVICES LIMITED TO 5 HOURS PER DAY.
5649	1/1/1900	BEHAVIORAL HEALTH DAY TREATMENT SERVICES LIMITED TO 5 HOURS PER DAY.
5650	1/1/2014	ONLY THE FIRST 20 DAYS OF A NURSING HOME STAY ARE COVERED.
5655	1/1/1900	ONE TABLET SPLITTING DEVICE ALLOWED PER YEAR. CLAIMS HISTORY INDICATES A HISTORY OF ANOTHER TABLET SPLITTING DEVICE IN THE PAST 365 DAYS
5660	1/1/1900	ALVELOPLASTY EXTRACTION NOT PAYABLE WHEN LESS THAN 3 TEETH ARE EXTRACTED PER QUADRANT.
5663	1/1/1900	CTP PROCEDURE T1016 LIMITED TO 32 UNITS PER DAY
5664	1/1/2014	CTS PROCEDURE T1016 LIMITED TO 32 UNITS PER DAY.
5665	1/1/1900	Tint procedures limited to 2 per 5 rolling years for members 21 and older.
5666	1/1/2014	EYE GLASSES FITTING LIMITED TO ONCE PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY.
5667	1/1/1900	One Pair of lenses per 5yrs/6 MOS surgery
5668	1/1/2014	PREGNANCY PROCEDURES H0023 AND S9470 LIMITED TO 8 PER 9 MONTHS
5669	1/1/1900	PREGNANCY PROCEDURES S9470, S9123 AND S9127 LIMITED TO 5 PER 9 MONTHS
5670	1/1/2014	EEPSDT COUNSELING OR SCREENING SERVICES LIMITED TO 1 PER STATE FISCAL YEAR.PSDTCounseling/Screening service Lim to 1 SFY
5681	1/1/1900	MENTAL HEALTH INDIVIDUAL THERAPY SERVICES LIMITED TO 36 PER STATE FISCAL YEAR
5682	1/1/2014	MENTAL HEALTH FAMILY THERAPY SERVICES LIMITED TO 24 PER STATE FISCAL YEAR.
5683	1/1/1900	MENTAL HEALTH GROUP THERAPY SERVICES LIMITED TO 40 PER STATE FISCAL YEAR.

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EOB Code	Effective Date	Description
5684	1/1/2014	MENTAL HEALTH CASE MANAGEMENT SERVICES LIMITED TO 260 PER STATE FISCAL YEAR.
5685	1/1/1900	PSYCHIATRIC OFFICE VISITS LIMITED TO 16 PER STATE FISCAL YEAR
5686	1/1/2014	MENTAL HEALTH ACUTE PARTIAL HOSPITAL SERVICES LIMITED TO 100 PER STATE FISCAL YEAR.
5687	1/1/1900	NURSING ASSESSMENT SERVICES LIMITED TO 144 PER STATE FISCAL YEAR
5688	1/1/2014	MENTAL HEALTH EPSDT INDIVIDUAL SERVICE LIMITED TO 36 PER STATE FISCAL YEAR.
5689	1/1/1900	MENTAL HEALTH EPSDT FAMILY SERVICES LIMITED TO 24 PER STATE FISCAL YEAR
5690	1/1/2014	MENTAL HEALTH EPSDT GROUP SERVICES LIMITED TO 40 PER STATE FISCAL YEAR.
5695	1/1/1900	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	1/1/1900	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	1/1/2014	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	1/1/1900	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	1/1/2014	INSULIN LIMITED TO 60 TOTAL CUMULATIVE MILLILITERS PER MONTH. IF HIGHER QTY NEEDED, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO DOM PA UNIT.
5703	1/1/1900	HYOSCYAMINE LIMITED TO 15 ML PER MONTH
5704	1/1/2014	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	1/1/1900	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	1/1/2014	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	1/1/1900	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	1/1/2014	CARISOPRODOL TABLETS LIMITED TO 84 PER 6 MONTHS. THE QUANTITY ON THE CLAIM PLUSPRESCRIPTION HISTORY EXCEEDS THE QUANTITY LIMIT FOR CARISOPRODOL.
5711	1/1/1900	DRUG MUST HAVE OPIOID PRESCRIPTION IN PAST 30 DAYS.
5712	1/1/1900	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

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EOB Code	Effective Date	Description
5713	1/1/1900	ONZETRA LIMITED TO 1 BOX / 16 UNITS PER MONTH
5715	1/1/1900	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	1/1/2014	B2I PRESCRIPTIONS LIMITED TO 8 PER MONTH. IF HIGHER QTY NEEDED, MUST SUBMIT MAXUNIT OVERRIDE REQUEST TO DOM PA UNIT.
5717	1/1/1900	BRAND LIMIT OF 5 PER MONTH EXCEEDED
5718	1/1/2014	BRAND LIMIT OF 5 PER MONTH EXCEEDED.
5720	1/1/2014	B2I PRESCRIPTIONS LIMITED TO 8 PER MONTH. IF HIGHER QTY NEEDED, MUST SUBMIT MAXUNIT OVERRIDE REQUEST TO DOM PA UNIT.
5721	1/1/1900	THE TOTAL NUMBER OF BRAND DRUGS FOR THIS MEMBER EXCEEDS THE 2 BRAND LIMIT PER CALENDAR MONTH
5725	1/1/1900	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	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR QUILLIVANT XR, MUST SUBMIT MAX UNIT OVERRIDEREQUEST TO A CLINICAL PA ONLY UNIT.
5729	1/1/1900	CHANTIX 1 MG CONT MONTH PAK LIMITED TO 56 UNITS IN 21 DAYS
5732	1/1/2014	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	1/1/1900	RX EXCEEDS MONTHLY LIMIT. ADDITIONAL PRESCRIPTIONS ALLOWED FOR BENEFICIARIES UNDER AGE 21 WITH PRIOR AUTHORIZATION.
5734	1/1/2014	RX EXCEEDS MONTHLY LIMIT.
5735	1/1/1900	MORE THAN TWO 72 HOUR EMERGENCY FILLS ATTEMPTED FOR THIS DRUG/STRENGTH THIS MONTH
5740	1/1/2014	HOSPITAL LEAVE DAYS ARE NOT PAYABLE WHEN 15 OR MORE HOSPITAL LEAVE DAYS HAVE ALREADY BEEN PAID.
5741	1/1/1900	LEAVE DAYS ARE NOT PAYABLE WHEN 15 OR MORE NURSING HOME LEAVE DAYS HAVE ALREADYBEEN PAID
5744	1/1/1900	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	1/1/1900	RESPITE CARE DAYS ARE LIMITED TO 5 CONSECUTIVE DAYS.
5746	1/1/1900	HOSPICE SERVICE INTENSITY ADD-ONS LIMITED TO 16 UNITS PER DAY.
5750	1/1/1900	PHARM Only 1 Disp Fee Per Drug Per Month
5755	1/1/1900	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	1/1/1900	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	1/1/1900	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
5761	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA REQUEST FOR GREATER QUANTITIES.
5762	1/1/1900	ORAL INHALER CUMULATIVE ROLLING MONTHLY QUANTITY LIMIT OF 17 GRAMS EXCEEDED.
5763	1/1/1900	ORAL INHALER CUMULATIVE ROLLING MONTHLY QUANTITY LIMIT OF 13.4 GRAMS EXCEEDED.
5764	1/1/1900	ORAL INHALER CUMULATIVE ROLLING MONTHLY QUANTITY LIMIT OF 16 GRAMS EXCEEDED.
5765	1/1/1900	ORAL INHALER CUMULATIVE ROLLING MONTHLY QUANTITY LIMIT OF 36 GRAMS EXCEEDED.
5769	1/1/1900	BOTOX INJECTION SERVICES LIMITED EXCEEDED PER 90 DAYS
5770	1/1/2014	BOTOX INJECTION SERVICES LIMITED EXCEEDED PER 90 DAYS.
5771	1/1/1900	BOTOX INJECTION SERVICES LIMITED EXCEEDED PER 90 DAYS
5772	1/1/2014	BOTOX INJECTION SERVICES LIMITED EXCEEDED PER 90 DAYS.
5775	1/1/1900	A QTY OF MORE THAN 3 SYRINGES PER YEAR REQUIRES A CLINICAL PA.
5776	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO CLINICAL PA ONLY UNIT.
5778	1/1/1900	EPSDT SCREENING LIMITED TO ONE.
5779	1/1/1900	EPSDT SCREENING LIMITED TO ONE.
5780	1/1/2014	EPSDT SCREENING LIMITED TO ONE.
5781	1/1/1900	EPSDT SCREENING LIMITED TO ONE
5782	1/1/2014	EPSDT SCREENING LIMITED TO ONE.
5783	1/1/1900	EPSDT SCREENING LIMITED TO ONE
5784	1/1/2014	EPSDT SCREENING LIMITED TO ONE.
5785	1/1/1900	EPSDT SCREENING LIMITED TO ONE
5786	1/1/2014	EPSDT SCREENING LIMITED TO ONE.
5787	1/1/1900	EPSDT SCREENING LIMITED TO ONE
5788	1/1/1900	EPSDT SCREENING LIMITED TO ONE.
5789	1/1/1900	Physical Assessment - 99382 99392 - 30 Months
5791	1/1/1900	PHYSICAL ASSESSMENT LIMITED TO ONE PER STATE FISCAL YEAR
5792	1/1/2014	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	1/1/1900	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	1/1/2014	PHYSICAL ASSESSMENT LIMITED TO ONE PER YEAR.
5795	1/1/1900	PHYSICAL ASSESSMENT LIMITED TO ONE PER STATE FISCAL YEAR
5796	1/1/2014	TRANSPORTATION LIMITED TO 52 PER STATE FISCAL YEAR.
5797	1/1/1900	DME IS LIMITED TO $13,885 PER STATE FISCAL YEAR
5798	1/1/2014	CAREGIVER SUPPORT IS LIMITED TO 416 UNITS PER STATE FISCAL YEAR.
5799	1/1/1900	ANNOVERA LIMITED TO 1 PERSCRIPTION PER 365 ROLLING DAYS. IF MORE IS NEEDED, PAIS REQUIRED.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
5800	1/1/2014	LIFE SKILLS TRAINING LIMITED TO 832 UNITS PER STATE FISCAL YEAR.
5801	1/1/1900	PEER SUPPORT LIMITED TO 416 UNITS PER STATE FISCAL YEAR
5802	1/1/2014	TRANSITION CARE LIMITED TO 416 UNITS PER B2I ELIGIBILITY PERIOD.
5803	1/1/1900	SECURITY DEPOSIT LIMITED TO $1,500 PER STATE FISCAL YEAR
5804	1/1/2014	HOME MODIFICATIONS LIMITED TO $5,000 PER STATE FISCAL YEAR.
5805	1/1/1900	MOVING EXPENSES LIMITED TO $300 PER STATE FISCAL YEAR
5806	1/1/2014	ADAPTIVE EQUIPMENT LIMITED TO $5,000 PER STATE FISCAL YEAR.
5807	1/1/1900	HOUSEHOLD GOODS LIMITED TO $3,000 PER STATE FISCAL YEAR
5808	1/1/1900	BAQSIMI LIMITED TO 2 UNITS PER 22 DAYS. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDEBY A CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5809	1/1/1900	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	1/1/2014	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	1/1/1900	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	1/1/2014	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	1/1/1900	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	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO CLINICAL PA ONLY UNIT.
5822	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO PA UNIT.
5823	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5824	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5825	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5826	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5827	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5828	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5829	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5830	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5831	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT

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EOB Code	Effective Date	Description
5832	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5833	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5834	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5835	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5837	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5838	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5880	1/1/2014	ESPDT SCREENING LIMITED TO ONE.
5881	1/1/1900	ESPDT SCREENING LIMITED TO ONE
5882	1/1/2014	ESPDT SCREENING LIMITED TO ONE.
5883	1/1/1900	ESPDT SCREENING LIMITED TO ONE
5884	1/1/2014	ESPDT SCREENING LIMITED TO ONE.
5885	1/1/1900	ESPDT SCREENING LIMITED TO ONE
5886	1/1/2014	ESPDT SCREENING LIMITED TO ONE.
5887	1/1/1900	ESPDT SCREENING LIMITED TO ONE
5888	1/1/2014	ESPDT SCREENING LIMITED TO ONE.
5889	1/1/1900	ESPDT SCREENING LIMITED TO ONE
5890	1/1/2014	ESPDT SCREENING LIMITED TO ONE.
5891	1/1/1900	ESPDT SCREENING LIMITED TO ONE
5892	1/1/2014	ESPDT SCREENING LIMITED TO ONE.
5893	1/1/1900	ESPDT SCREENING LIMITED TO ONE
5894	1/1/2014	ESPDT SCREENING LIMITED TO ONE.
5895	1/1/1900	ESPDT SCREENING LIMITED TO ONE
5896	1/1/2014	ESPDT SCREENING LIMITED TO ONE.
5897	1/1/1900	ESPDT SCREENING LIMITED TO ONE
5900	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5901	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5902	1/1/2014	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5903	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5904	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.

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EOB Code	Effective Date	Description
5905	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5906	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5907	1/1/1900	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	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5910	1/1/2014	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	1/1/1900	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	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5913	1/1/1900	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	1/1/2014	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	1/1/1900	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	1/1/2014	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	1/1/1900	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	1/1/2014	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	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5920	1/1/2014	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	1/1/1900	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
5922	1/1/2014	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	1/1/1900	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	1/1/1900	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	1/1/2014	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	1/1/1900	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	1/1/1900	PHARM QL 17 PER 23 DAYS (BP 100,200,400)
5930	1/1/2014	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	1/1/1900	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	1/1/2014	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	1/1/1900	KETOROLAC TABLETS LIMITED TO 20 PER 23 DAYS.
5943	1/1/1900	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	1/1/2014	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	1/1/1900	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	1/1/2014	PHARM QL Proair 2 PER 23 DAYS (BP 100,200,400)
5947	1/1/1900	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
5948	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT
5949	1/1/1900	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
5950	1/1/2014	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	1/1/2014	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
5953	1/1/1900	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	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5955	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5956	1/1/2014	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5957	1/1/1900	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	1/1/2014	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	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5960	1/1/2014	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5961	1/1/1900	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	1/1/2014	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5963	1/1/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5964	1/1/2014	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	1/1/1900	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
5966	1/1/2014	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	1/1/1900	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	1/1/2014	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	1/1/1900	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	1/1/2014	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	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5972	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5973	1/1/1900	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	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5975	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5976	1/1/2014	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	1/1/1900	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	1/1/2014	SUBMITTED QTY EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAY SUBMIT MAXUNIT OVERRIDE BY CLINICAL PA ONLY REQUEST IF GREATER QTY NEEDED.
5983	1/1/1900	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	1/1/2014	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5985	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5986	1/1/2014	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
5987	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5988	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5989	1/1/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5990	1/1/2014	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	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
5992	1/1/2014	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	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5994	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
5995	1/1/1900	ER BENZOS HAVE A CUMULATIVE QUANTITY LIMIT OF 31 TABLETS/26 DAYS.
5996	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
5997	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
5998	1/1/2014	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.
5999	1/1/1900	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	1/1/1900	PENDING MANUAL PRICING
6001	1/1/1900	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	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
6004	1/1/2014	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	1/1/1900	PHARM QL BENZO 31 PER 26 DAYS (BP 200,400)
6006	1/1/2014	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.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6007	1/1/1900	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	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT FOR INSULIN PEN, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
6009	1/1/1900	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	1/1/2014	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	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6012	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6013	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6014	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6015	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6017	1/1/1900	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	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6019	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6020	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6021	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6022	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6023	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6024	1/1/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6025	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT OF 62 TABS IN 31 DAYS, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
6027	1/1/1900	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
6028	1/1/2014	EXCEEDS MONTHLY QUANTITY LIMIT, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
6029	1/1/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6030	1/1/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6031	1/1/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6032	1/1/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6033	1/1/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6034	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6035	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6036	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6037	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
6038	1/1/2014	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	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
6040	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
6041	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
6042	1/1/2014	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED.
6043	1/1/1900	SUBMITTED QTY OR # OF RXS EXCEEDS THE ALLOWED QTY FOR THIS DRUG. PRESCRIBER MAYSUBMIT MAX UNIT OVERRIDE PA REQUEST IF GREATER QTY NEEDED
6044	1/1/2014	PHARM QL Vaccines 0.5 PER 9999 DAYS (BP100,400)
6045	1/1/1900	THE QUANTITY ON THE HYSINGLA ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6046	1/1/1900	THE QUANTITY ON THE ZOHYDRO ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG

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EOB Code	Effective Date	Description
6047	1/1/1900	THE QUANTITY ON THE METHADONE CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6048	1/1/1900	THE QUANTITY ON THE MORPHINE ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6049	1/1/1900	THE QUANTITY ON THE XTAMPZA ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6050	1/1/1900	THE QUANTITY ON THE BUTRANS CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYSEXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6051	1/1/1900	THE QUANTITY ON THE BELBUCA CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYSEXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6052	1/1/1900	THE QUANTITY ON THE ARYMO ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6053	1/1/1900	THE QUANTITY ON THE MORPHABOND ER CLAIM PLUS PRESCRIPTION HISTORY IN THE PAST 26 DAYS EXCEEDS THE QUANTITY LIMIT FOR THIS DRUG
6055	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6056	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6062	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
6063	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6064	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6065	1/1/1900	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
6066	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
6067	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
6068	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6069	1/1/1900	EXCEEDS MONTHLY QUANTITY LIMIT, MUST SUBMIT MAX UNIT OVERRIDE REQUEST TO A CLINICAL PA ONLY UNIT.
6071	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
6072	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	NEBULIZER SOLUTION CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6076	1/1/1900	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	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6078	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE BY A CLINICAL PA ONLY REQUEST FOR GREATER QUANTITIES.
6079	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6080	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6081	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6082	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6083	1/1/1900	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
6084	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6085	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6086	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6087	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6088	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6089	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6090	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6091	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6092	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6095	1/1/1900	ORAL INHALERS CUMULATIVE ROLLING MONTHLY QTY. LIMIT EXCEEDED. PRESCRIBER MAY SUBMIT MAX UNIT OVERRIDE PA REQUEST FOR GREATER QUANTITIES.
6100	1/1/1900	SIMVASTATIN 80 MG IS LIMITED TO 1 PER DAY. IF MORE IS NEEDED, CLINICAL PA IS REQUIRED.
6101	1/1/1900	SIMVASTATIN 40 MG IS LIMITED TO 2 PER DAY. IF MORE IS NEEDED, CLINICAL PA IS REQUIRED.
6102	1/1/1900	SIMVASTATIN 20 MG IS LIMITED TO 4 PER DAY. IF MORE IS NEEDED, CLINICAL PA IS REQUIRED.
6103	1/1/1900	SIMVASTATIN 10 MG IS LIMITED TO 8 PER DAY. IF MORE IS NEEDED, CLINICAL PA IS REQUIRED.
6392	1/1/2014	THIS SERVICE IS NOT PAYABLE WITH ANOTHER SERVICE ON THE SAME DATE OF SERVICE DUE TO NATIONAL CORRECT CODING INITIATIVE.
6393	1/1/1900	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	1/1/1900	THIS SERVICE IS NOT PAYABLE WITH ANOTHER SERVICE ON THE SAME DATE OF SERVICE DUE TO NATIONAL CORRECT CODING INITIATIVE.
6395	1/1/1900	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	1/1/2014	MILEAGE PROCEDURE CODE BILLED WITHOUT A BASE RATE CODE.
6401	1/1/1900	VACCINE ADMINISTRATION CODE NOT PAYABLE WITHOUT VFC VACCINE PAID ON SAME DATE OF SERVICE
6402	1/1/2014	Not Used

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6403	1/1/1900	VACCINE ADMINISTRATION MUST BE BILLED WITH A VACCINE CODE FOR THE SAME DATE OFSERVICE BY THE SAME PROVIDER
6404	1/1/2014	IMMUNIZATION ADMINISTRATION MUST BE BILLED WITH THE IMMUNIZATION VACCINE OR TOXOID FOR THE SAME DATE OF SERVICE.
6405	1/1/1900	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	1/1/2014	SURGICAL TRAY MUST BE BILLED WITH APPROVED SURGICAL CODE.
6408	1/1/2014	CRITICAL CARE ADD ON MUST BE BILLED WITH CRITICAL CARE PRIMARY PROCEDURE FOR THE SAME DATE OF SERVICE BY THE SAME PROVIDER.
6409	1/1/1900	TINT PROCEDURES CANNOT BE BILLED WITHOUT A PAID LENS PROCEDURE
6410	1/1/2014	REUSE
6411	1/1/1900	SURGICAL SERVICES AND ROUTINE PREOPERATIVE MEDICAL VISITS ARE NOT SEPARATELY PAYABLE. A PREVIOUSLY PAID ROUTINE PREOPERATIVE MEDICAL VISIT IS BEING RECOUPED
6415	1/1/1900	Multiple Surgeries Not Allowed Same DOS Same Claim
6420	1/1/2014	ASSISTANT SURGEON/SURGEON MUST FILE SEPARATELY
6421	1/1/1900	IMPROPER USE OF ASSISTANT SURGEON MODIFIERS
6422	1/1/2014	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	1/1/1900	FAMILY PLANNING SERVICE BILLED AFTER STERILIZATION OR HYSTERECTOMY SERVICE
6426	1/1/2014	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	1/1/2014	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	1/1/1900	TBD
6432	1/1/1900	90472 must be billed with 2 Vaccines - same claim
6435	1/1/1900	CONCOMITANT USE OF A GLP-1 AND A DPP-4 HYPOGLYCEMIC AGENT REQUIRES A CLINICAL PA FOR APPROVAL
6437	1/1/1900	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	1/1/1900	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	1/1/1900	DELIVERY SERVICES LIMITED TO ONCE PER 8 MONTHS
6460	1/1/1900	DRUG MUST HAVE OPIOID PRESCRIPTION IN PAST 30 DAYS.
6461	1/1/1900	SA & LA NARCOTIC NOT ALLOWED WITH SUBOXONE IN THE PAST 30 DAYS. REQUIRES A CLINICAL PA FOR APPROVAL.

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EOB Code	Effective Date	Description
6502	1/1/1900	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	1/1/1900	MULTIPLE TRIVALENT VACCINES NOT PAYABLE ON THE SAME DATE OF SERVICE BY THE SAMEPROVIDER
6505	1/1/1900	90460 AND 90471-90474 ARE NOT PAYABLE ON THE SAME DATE OF SERVICE BY THE SAME RENDERING PROVIDER
6506	1/1/2014	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	1/1/1900	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	1/1/1900	PRADAXA 110 MG IS NOT INDICATED FOR KNEE REPLACEMENT SURGERY.
6511	1/1/1900	DENTAL SERVICES CANNOT BE BILLED FOR A PREVIOUSLY EXTRACTED TOOTH
6512	1/1/2014	DENTAL EXTRACTION HAS ALREADY BEEN PAID FOR THE SAME TOOTH.
6513	1/1/1900	ALVEOLECTOMY SURGICAL EXTRACTION LIMITED TO 1 PER AREA OF ORAL CAVITY PER DATEOF SERVICE
6515	1/1/1900	ROOT TIP REMOVAL NOT ALLOWED ON SAME DATE OF SERVICE, SAME TOOTH, AS EXTRACTION.
6516	1/1/1900	ROOM AND BOARD AND THERAPEUTIC LEAVE ARE NOT PAYABLE FOR SAME OR OVERLAPPING DATES OF SERVICE.
6518	1/1/2014	DME REPLACEMENT/REPAIR BILLED BEFORE PURCHASE
6519	1/1/1900	ENCOUNTER PROCEDURE FOUND ON SAME DATE OF SERVICE
6521	1/1/1900	LENSES LIMITED TO ONE PAIR PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY
6525	1/1/1900	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	1/1/2014	TBD
6527	1/1/1900	TBD
6528	1/1/2014	TBD
6529	1/1/1900	TBD
6530	1/1/2014	EYE GLASSES FITTING LIMITED TO ONCE PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY.
6531	1/1/1900	FRAMES LIMITED TO ONCE PER 5 ROLLING YEARS AND ONCE WITHIN 6 MONTHS OF SURGERY.
6535	1/1/1900	OUTPATIENT HOSPITAL SERVICE NOT ALLOWED WITH ANOTHER PAID OUTPATIENT HOSPITAL SERVICE WITH OVERLAPPING DATES OF SERVICE BY THE SAME PROVIDER.
6536	1/1/1900	G0378 MUST BE BILLED ONLY ONCE PER CLAIM.
6537	1/1/1900	EMR visits must include ET modifier on 2nd day services. A claim in history foran EMR visit is paid for overlapping dates of services.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
6540	1/1/2014	SAME SEDATIVE HYPNOTIC PAID WITHIN THE PAST 25 DAYS.
6545	1/1/1900	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	1/1/1900	MULTIPLE VACCINES FOR THE SAME DOS MUST BE BILLED ON THE SAME CLAIM.
6590	1/1/2014	ADD-ON CODES ARE PERFORMED IN ADDITION TO THE PRIMARY SERVICE OR PROCEDURE ANDCANNOT BE REPORTED AS A STAND-ALONE SERVICE.
6600	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	CLAIM GENERATED AN INFORMATIONAL PRODUR ALERT
7002	1/1/1900	MINIMUM DURATION OF THERAPY PROSPECTIVE DUR ALERT.
7003	1/1/1900	DRUG-DRUG INTERACTION PROSPECTIVE DUR ALERT
7004	1/1/1900	DD PROSPECTIVE DUR ALERT; EOB NOT USED
7005	1/1/1900	DRUG-DISEASE (REPORTED) PROSPECTIVE DUR ALERT
7006	1/1/1900	MC PROSPECTIVE DUR ALERT; EOB NOT USED
7007	1/1/1900	DRUG-DISEASE (INFERRED) PROSPECTIVE DUR ALERT
7008	1/1/1900	DC PROSPECTIVE DUR ALERT; EOB NOT USED
7009	1/1/1900	THERAPEUTIC DUPLICATION PROSPECTIVE DUR ALERT
7010	1/1/1900	DRUG-PREGNANCY PROSPECTIVE DUR ALERT
7011	1/1/1900	EARLY REFILL PROSPECTIVE DUR ALERT
7012	1/1/1900	ADDITIVE TOXICITY PROSPECTIVE DUR ALERT
7013	1/1/1900	DRUG-AGE PROSPECTIVE DUR ALERT
7014	1/1/1900	INGREDIENT DUPLICATION PROSPECTIVE DUR ALERT.
7015	1/1/1900	LATE REFILL PROSPECTIVE DUR ALERT
7016	1/1/1900	HIGH DOSE PROSPECTIVE DUR ALERT
7017	1/1/1900	MAXIMUM DURATION OR THERAPY PROSPECTIVE DUR ALERT.
7018	1/1/1900	LOW DOSE PROSPECTIVE DUR ALERT.
7019	1/1/1900	EARLY REFILL ALERT. POLICY OVERRIDE MUST BE GRANTED BY THE DRUG AUTHORIZATIONAND POLICY OVERRIDE CENTER TO DISPENSE EARLY.
7020	1/1/1900	RESERVED FOR FUTURE USE.
7021	1/1/1900	RESERVED FOR FUTURE USE.
7022	1/1/1900	RESERVED FOR FUTURE USE.
7200	1/1/1900	SERVICE ROUTINELY COVERED ONCE PER SIX MONTHS. PAYMENT HAS ALREADY BEEN MADE. FOR REVIEW OF MEDICAL NECESSITY, RESUBMIT WITH FULL DOCUMENTATION.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
7201	1/1/1900	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	1/1/1900	PROCEDURE IS INVALID FOR PATIENT'S AGE
7212	1/1/1900	PROCEDURE ADDED DUE TO ALT CODE REPLACEMENT (AGE)
7213	1/1/1900	PROCEDURE IS INVALID FOR PATIENT'S SEX
7214	1/1/1900	PROCEDURE ADDED DUE TO ALT CODE REPLACEMENT (SEX)
7215	1/1/1900	PROCEDURE CODE IS INCIDENTAL
7217	1/1/1900	PROCEDURE CODE HAS BEEN REBUNDLED
7218	1/1/1900	PROCEDURE ADDED DUE TO REBUNDLING
7219	1/1/1900	PROCEDURE IS MUTUALLY EXCLUSIVE
7233	1/1/1900	DENIED DUPLICATE- INCLUDES UNILATERAL OR BILAT
7234	1/1/1900	DENIED DUPLICATE - IS BILATERAL
7235	1/1/1900	DENIED DUPLICATE - ONLY DONE XX TIMES IN LIFETIME
7236	1/1/1900	DENIED DUPLICATE - ONLY DONE XX TIMES IN A DAY
7237	1/1/1900	DENIED DUPLICATE (REBUNDLED)
7238	1/1/1900	PROCEDURE ADDED DUE TO DUPLICATE REBUNDLING
7239	1/1/1900	PROCEDURE IS A POSSIBLE DUPLICATE
7256	1/1/1900	MODIFIER INVALID FOR PROCEDURE CODE BILLED.
7257	1/1/1900	INCIDENTAL MODIFIER IS REQUIRED FOR SECONDARY PROCEDURE CODE.
7258	1/1/1900	REVIEW MODIFIER 51
7259	1/1/1900	SPLIT DECISION WAS RENDERED ON EXPANSION OF UNITS.
7290	1/1/1900	INVALID MODIFIER REMOVED FROM PRIMARY PROCEDURE CODE BILLED.
7291	1/1/1900	INCIDENTAL MODIFIER WAS ADDED TO THE SECONDARY PROCEDURE CODE.
7500	1/1/1900	BILLING PROVIDER ON PREPAYMENT REVIEW
7503	1/1/1900	REASON FOR SERVICE SUBMITTED DOES NOT MATCH PROSPECTIVE DUR DENIAL ON ORIGINALCLAIM.
7504	1/1/1900	DENIED. PROFESSIONAL SERVICE CODE IS INVALID.
7505	1/1/1900	DENIED. RESULT OF SERVICE CODE IS INVALID.
7506	1/1/1900	DENIED. PROSPECTIVE DUR DENIAL ON ORIGINAL CLAIM CAN NOT BE OVERRIDDEN.
7507	1/1/1900	DENIED. RESULT OF SERVICE SUBMITTED INDICATES THE PRESCRIPTION WAS "NOT FILLED".
7508	1/1/1900	DENIED. RESULT OF SERVICE SUBMITTED INDICATES THE PRESCRIPTION WAS FILLED WITHA DIFFERENT QUANTITY. QUANTITY SUBMITTED MATCHES ORIGINAL CLAIM.
8000	1/1/1900	RESOLUTION REVIEW.
8001	1/1/1900	NOT USED - DMAP WAS UNABLE TO PROCESS THIS REQUEST DUE TO ILLEGIBLE INFORMATION.
8002	1/1/1900	UNABLE TO PROCESS THIS REQUEST DUE TO EITHER MISSING, INVALID OR MISMATCHED NATIONAL PROVIDER IDENTIFIER # (NPI)/PROVIDER NAME/POP ID.
8003	1/1/1900	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.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
8004	1/1/1900	NOT USED - DMAP WAS UNABLE TO PROCESS THIS REQUEST. THE RESIDENT OR CNA'S NAMEI S MISSING.
8005	1/1/1900	NOT USED - DMAP WAS UNABLE TO PROCESS THIS REQUEST. ALL REQUESTS MUST HAVE A 9D IGIT SOCIAL SECURITY NUMBER.
8006	1/1/1900	NOT USED - DMAP IS UNABLE TO PROCESS THIS REQUEST BECAUSE THE SIGNATURE/DATE FIEL D IS BLANK
8007	1/1/1900	THE SCREEN DATE IS EITHER MISSING OR INVALID. THE SCREEN DATE MUST BE IN MM/DD/CCYY FORMAT.
8008	1/1/1900	OBRA-NURSE AND/OR LEVEL 1.
8009	1/1/1900	INVALID ADMISSION DATE. EITHER THE DATE WAS NOT IN MM/DD/CCYY FORMAT OR IT'S AFUTURE DATE.
8010	1/1/1900	THIS IS NOT A REIMBURSABLE LEVEL I SCREEN. DID YOU CHECK MORE THAN ONE BOX? IFSO, CORRECT AND RESUBMIT.
8011	1/1/1900	REQUEST DENIED BECAUSE THE SCREEN DATE IS AFTER THE ADMISSION DATE. THIS IS NOT A PREADMISSION SCREEN AND IS NOT REIMBURSABLE.
8012	1/1/1900	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	1/1/1900	REQUEST DENIED BECAUSE THE SCREEN WAS DONE MORE THAN 90 DAYS PRIOR TO THE ADMISSION DATE.
8014	1/1/1900	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	1/1/1900	THE REIMBURSEMENT CODE ASSIGNED TO THIS CERTIFICATION SEGMENT DOES NOT AUTHORIZE A NAT PAYMENT.
8016	1/1/1900	THE REIMBURSEMENT CODE ASSIGNED TO THIS CERTIFICATION SEGMENT DOES NOT AUTHORIZE A TRAINING PAYMENT. THE CNA IS ONLY ELIGIBLE FOR TESTING REIMBURSEMENT.
8017	1/1/1900	UNABLE TO PROCESS THIS REQUEST BECAUSE THE "COMPETENCY TEST DATE" AND "TRAININGCOMPLETION DATE" FIELDS ARE BLANK.
8018	1/1/1900	COMPETENCY TEST DATE IS NOT A VALID DATE. IT MUST BE IN MM/DD/YY FORMAT ANDCAN NOT BE A FUTURE DATE.
8019	1/1/1900	TRAINING COMPLETION DATE IS NOT A VALID DATE. IT MUST BE IN MM/DD/YY FORMATAND CAN NOT BE A FUTURE DATE.
8020	1/1/1900	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	1/1/1900	NOT USED - WI DMAP CAN NOT ISSUE A NAT PAYMENT WITHOUT A VALID HIRE DATE.
8022	1/1/1900	CNAS ELIGIBILITY FOR NAT REIMBURSEMENT HAS EXPIRED. THE TIMEFRAME BETWEEN CERTIFICATION, TEST, DATE AND HIRE DATE EXCEEDS A YEAR.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
8023	1/1/1900	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	1/1/1900	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	1/1/1900	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	1/1/1900	NF'S ELIGIBILITY FOR REIMBURSEMENT HAS EXPIRED. REQUESTS FOR TRAINING REIMBURSEMENT DENIED DUE TO LATE BILLING.
8027	1/1/1900	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	1/1/1900	CNAS ELIGIBILITY FOR TRAINING REIMBURSEMENT HAS EXPIRED. "TRAINING COMPLETIONDATE" EXCEEDS THE CURRENT ELIGIBILITY TIMELINE.
8029	1/1/1900	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	1/1/1900	THE REIMBURSEMENT CODE ASSIGNED TO THIS CNA DOES NOT AUTHORIZE A NAT PAYMENT.
8032	1/1/1900	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	1/1/1900	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	1/1/1900	MULTIPLE REQUESTS RECEIVED FOR THIS SSN WITH THE SAME SCREEN DATE. A PAYMENT HAS ALREADY BEEN ISSUED TO A DIFFERENT NF.
8035	1/1/1900	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	1/1/1900	A TRAINING PAYMENT HAS ALREADY BEEN ISSUED TO A DIFFERENT NF FOR THIS CNA.
8037	1/1/1900	A TRAINING PAYMENT HAS ALREADY BEEN ISSUED TO YOUR NF FOR THIS CNA.
8038	1/1/1900	REIMBURSEMENT FOR TRAINING IS ONE TIME ONLY. A TRAINING PAYMENT HAS ALREADY BEEN ISSUED FOR THIS CNA.
8039	1/1/1900	A PAYMENT FOR THE CNA'S COMPETENCY TEST HAS ALREADY BEEN ISSUED.
8040	1/1/1900	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	1/1/1900	REIMBURSEMENT FOR THIS CERTIFICATION, TEST, SEGMENT HAS BEEN ISSUED TO ANOTHERNF.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
8042	1/1/1900	REIMBURSEMENT FOR THIS CERTIFICATION, TEST, SEGMENT HAS ALREADY BEEN ISSUED TOYOUR NF.
8183	1/1/1900	PATIENT LIABILITY ADJUSTMENTS
8186	1/1/1900	MASS ADJUSTMENT - PROVIDER RATE PROCESS.
8188	1/1/1900	MASS ADJUSTMENT - VOID TRANSACTIONS
8192	1/1/1900	THIS CLAIM HAS BEEN ADJUSTED DUE TO MEDICARE PART D COVERAGE.
8193	1/1/1900	THIS CLAIM HAS BEEN ADJUSTED DUE TO A CHANGE IN THE MEMBER'S ENROLLMENT.
8194	1/1/1900	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	1/1/1900	PROVIDER REQUEST CASH ADJUSTMENT
8196	1/1/1900	PROVIDER REQUEST CASH VOID
8197	1/1/1900	PROVIDER REQUEST TPL CASH ADJUSTMENT
8198	1/1/1900	PROVIDER REQUEST TPL CASH VOID
8200	5/1/1994	TPL PRIVATE HEALTH INSURANCE - CARRIER
8201	5/1/1994	TPL PRIVATE HEALTH INSURANCE - PROVIDER
8202	5/1/1994	TPL PRIVATE HEALTH INSURANCE - MEMBER
8203	5/1/1994	AUTO LIABILITY - CARRIER
8204	1/1/1990	AUTO LIABILITY - PROVIDER
8205	1/1/1994	AUTO LIABILITY - MEMBER
8206	1/1/1990	NON-AUTO LIABILITY - CARRIER
8207	1/1/1990	NON-AUTO LIABILITY - PROVIDER
8208	1/1/1994	NON-AUTO LIABILITY - MEMBER
8209	1/1/1990	WORKER'S COMP - CARRIER
8210	1/1/1990	WORKER'S COMP - PROVIDER
8211	1/1/1994	WORKER'S COMP - MEMBER
8212	1/1/1990	PROBATE'S ESTATE
8213	1/1/1990	INCOME PENSION TRUST RECOVERIES
8214	1/1/1990	VICTIM'S RESTITUTION
8215	1/1/1994	ABSENT PARENTS
8216	1/1/1994	TPL ERROR
8217	1/1/1994	DUE TO MISCELLANEOUS OR UNSPECIFIED REASON
8220	1/1/1900	RESERVED FOR FUTURE USE.
8221	1/1/1900	RESERVED FOR FUTURE USE.
8222	1/1/1900	ADJUSTMENT/RESUBMISSION WAS INITIATED BY PROVIDER
8223	1/1/1900	RESERVED FOR FUTURE USE.
8224	1/1/1900	RESERVED FOR FUTURE USE.
8225	5/1/1994	CAPITATION - DEATH OF MEMBER
8226	1/1/1999	CAPITATION - MEMBER INCARCERATED
8227	1/1/1990	CAPITATION - EPSDT CLAIM
8228	1/1/1990	CAPITATION - MEMBER ENROLLED IN ERROR

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
8229	5/1/1994	CAPITATION - FAMILY PLANNING
8230	5/1/1994	CAPITATION - INCORRECT RATE CATEGO
8231	5/1/1994	CAPITATION - DEMOGRAPHIC CHANGE
8232	5/1/1994	CAPITATION - OTHER
8233	1/1/1900	ADJUSTMENT/RESUBMISSION WAS INITIATED BY DOM
8234	1/1/1900	NOT USED- DMAP-INITIATED CLAIM ADJUSTMENT. SEE TOPIC #13437 IN THE ONLINE HANDBO OK FOR COMPLETE INFORMATION ON THIS TYPE OF CLAIM ADJUSTMENT.
8240	1/1/1994	ADJUSTMENT GENERATED DUE TO SUR REVIEW
8241	1/1/1994	ADJUSTMENT GENERATED DUE TO CHANGE IN PATIENT LIABILITY
8242	1/1/1994	ADJUSTMENT GENERATED DUE TO RATE CHANGE
8244	1/1/1994	PAYOUT PROCESSED DUE TO DISPROPORTIONATE SHARE
8245	1/1/1900	POINT OF SALE
8246	1/1/1900	POINT OF SALE REVERSAL
8299	1/1/1990	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	1/1/1900	FINANCIAL CHECK VOID/STOP PAY
8515	1/1/1900	THIS CLAIM HAS BEEN DENIED DUE TO A POS REVERSAL TRANSACTION.
8901	1/1/1900	OTHER COMMERCIAL INSURANCE RESPONSE NOT RECEIVED WITHIN 90 DAYS FOR PROVIDER BASED BILL.
8902	1/1/1900	OTHER MEDICARE PART A RESPONSE NOT RECEIVED WITHIN 90 DAYS FOR PROVIDER BASED BILL.
8903	1/1/1900	OTHER MEDICARE PART B RESPONSE NOT RECEIVED WITHIN 90 DAYS FOR PROVIDER BASED BILL.
8904	1/1/1900	OTHER MEDICARE MANAGED CARE RESPONSE NOT RECEIVED WITHIN 120 DAYS FOR PROVIDERBASED BILL.
8999	1/1/1900	SUPERSUSPENDED FOR MISSING DISPOSITION
9000	1/1/1900	PRICING ADJUSTMENT - THE SUBMITTED CHARGE EXCEEDS THE ALLOWED CHARGE. CLAIM PAID AT THE PROGRAM ALLOWED AMOUNT.
9001	1/1/1900	PRICING ADJUSTMENT - REIMBURSEMENT REDUCED BY THE MEMBER'S COPAYMENT AMOUNT.
9002	1/1/2000	PRICING ADJUSTMENT - PAYMENT AMOUNT INCREASED BASED ON AMBULATORY SURGERY CENTERS ACCESS PAYMENT POLICIES.
9003	1/1/1900	PRICING ADJUSTMENT - THIRD PARTY LIABILITY AMOUNT APPLIED IS GREATER THAN THE AMOUNT PAID BY THE PROGRAM.
9004	1/1/1900	PRICING ADJUSTMENT - AMOUNT PAID IS ZERO.
9005	1/1/1900	THIS CLAIM IS ELIGIBLE FOR ELECTRONIC SUBMISSION. UP TO A $1.10 REDUCTION HAS BEEN APPLIED TO THIS CLAIM PAYMENT.
9006	1/1/1900	ACCESS PAYMENT INCLUDED.
9007	1/1/1900	ACCESS PAYMENT NOT AVAILABLE FOR DATE OF SERVICE ON THIS DATE OF PROCESS.

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
9008	1/1/1900	PRICING ADJUSTMENT - PAYMENT AMOUNT DECREASED BASED ON PAY FOR PERFORMANCE POLICY.
9013	1/1/1900	PHARMACEUTICAL CARE DENIED. TRADITIONAL DISPENSING FEE MAY BE ALLOWED.
9020	1/1/1900	SERVICE PAID IN ACCORDANCE WITH PROGRAM REQUIREMENTS.
9700	1/1/1900	TPL VENDOR INITIATED - VOID REVERSAL RESUBMISSION
9800	1/1/1900	PRICING ADJUSTMENT- ENCOUNTER CLAIM ZERO PAID.
9801	1/1/1900	CLAIM PAID AT PER DIEM RATE
9802	1/1/1900	CLAIM PAID AT % OF BILLED CHARGES
9803	1/1/1900	PRICING ADJUSTMENT - MEDICARE BENEFITS ARE EXHAUSTED. CLAIM PAID AT PROGRAM ALLOWED RATE.
9804	1/1/1900	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	1/1/1900	PRICING ADJUSTMENT - PAYMENT REDUCED DUE TO THE INPATIENT OR OUTPATIENT DEDUCTIBLE.
9806	1/1/1900	PRICING ADJUSTMENT - PAYMENT REDUCED DUE TO BENEFIT PLAN LIMITATIONS.
9807	1/1/1900	HEADER BILLING PROVIDER USED AS DETAIL PERFORMING PROVIDER
9808	1/1/1900	HEADER PERFORMING PROVIDER USED AS DETAIL PERFORMING PROVIDER
9809	1/1/1900	PRICING ADJUSTMENT - MAXIMUM ALLOWABLE FEE PRICING USED.
9810	1/1/1900	REPACKAGING ALLOWANCE APPLIED
9811	1/1/1900	PHARMACEUTICAL CARE RATE APPLIED.
9812	1/1/1900	LEVEL OF EFFORT DISPENSING FEE APPLIED.
9813	1/1/1900	TRADITIONAL DISPENSING FEE APPLIED.
9814	1/1/1900	DIAGNOSIS REQUIRED FOR PHARMACEUTICAL CARE. TRADITIONAL DISPENSING FEE MAY BE ALLOWED.
9815	1/1/1900	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	1/1/1900	PRICING ADJUSTMENT - PAYMENT AMOUNT INCREASED BASED ON HOSPITAL ACCESS PAYMENTPOLICIES.
9817	9/14/2009	BILLING PROVIDER NUMBER WAS USED TO ADJUDICATE THE SERVICE(S)
9818	1/1/1900	REPACKAGING ALLOWANCE IS NOT ALLOWED FOR UNIT DOSE NDCS.
9819	1/1/1900	EAPG PRICING APPLIED.
9820	1/1/1900	DRG INTERIM PER DIEM PRICING APPLIED
9821	1/1/1900	DRG POLICY ADJUSTOR APPLIED
9822	1/1/1900	DRG TRANSFER PRICING APPLIED
9823	1/1/1900	DRG DAY OUTLIER APPLIED
9824	1/1/1900	DRG COST OUTLIER APPLIED
9825	1/1/1900	DRG PRORATE PRICING APPLIED
9850	1/1/1900	Copay Bypass - Copay N/A
9851	1/1/1900	Copay Bypass - Child

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
9852	1/1/1900	Copay Bypass - Tribal/American Indian
9853	1/1/1900	Copay Bypass - Provider Exempt
9854	1/1/1900	Copay Bypass - Family Planning
9855	1/1/1900	Copay Bypass - Pregnancy
9856	1/1/1900	Copay Bypass - COVID
9857	1/1/1900	Copay Bypass - HCBS
9858	1/1/1900	Copay Bypass - NH Resident
9859	1/1/1900	Copay Bypass - Mental Health
9860	1/1/1900	Copay Bypass - RHC
9861	1/1/1900	Copay Bypass - Emergency
9862	1/1/1900	Copay Bypass - Breast/Cervical Cancer
9863	10/4/2020	COPAY BYPASS - ADULT VACCINES
9880	1/1/1900	VACCINE - ADMINISTRATION FEE PAID.
9881	1/1/1900	THE PHARMACY SUBMITTED A PROFESSIONAL SERVICE CODE VALUE 'MA' FOR COVID-19 VACCINE ADMINISTRATION.
9882	1/1/1900	VACCINE - NO DISPENSING FEE PAID.
9900	1/1/1900	THE NATIONAL DRUG CODE (NDC) WAS REIMBURSED AT A GENERIC RATE.
9902	1/1/1900	PRICING ADJUSTMENT - INPATIENT PER DIEM PRICING APPLIED
9904	1/1/1900	PRICING ADJUSTMENT - MEDICARE COINSURANCE AND DEDUCTIBLE
9905	1/1/1900	MEDICARE COINSURANCE CAP RULE APPLIED
9906	1/1/1900	PRICING ADJUSTMENT - MEDICARE PRICING CUTBACKS APPLIED.
9907	1/1/1900	PRICING ADJUSTMENT - THIRD PARTY LIABILITY DEDUCTIBLE AMOUNT APPLIED.
9908	1/1/1900	PHARMACY PRICING APPLIED.
9909	1/1/1900	PRICING ADJUSTMENT - PAID ACCORDING TO PROGRAM POLICY.
9910	1/1/1900	PHARMACY DISPENSING FEE APPLIED.
9911	1/1/1900	PRICING ADJUSTMENT - LTC PER DIEM PRICING APPLIED
9912	1/1/1900	PRICING ADJUSTMENT - AMBULATORY SURGERY PRICING APPLIED.
9914	1/1/1900	PRICING ADJUSTMENT - REVENUE CODE FLAT RATE PRICING APPLIED.
9915	1/1/1900	PRICING ADJUSTMENT - MEDICARE CROSSOVER CLAIM CUTBACK APPLIED.
9916	1/1/1900	PRICING ADJUSTMENT - USUAL & CUSTOMARY CHARGE (UCC) RATE PRICING APPLIED.
9917	1/1/1900	PRICING ADJUSTMENT - MEDICARE CROSSOVER PRICED PER DIVISION OF MEDICAID POLICY.
9918	1/1/1900	PRICING ADJUSTMENT - PROCEDURE MAX FEE PRICING APPLIED
9919	1/1/1900	PRICING ADJUSTMENT - ZERO PAID AMOUNT OR LEVEL OF CARE PRICING APPLIED.
9920	1/1/1900	PRICING ADJUSTMENT - RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) PRICING APPLIED.
9921	1/1/1900	PRICING ADJUSTMENT - PRIOR AUTHORIZATION PRICING APPLIED.
9922	1/1/1900	PRICING ADJUSTMENT - SPENDDOWN DEDUCTIBLE APPLIED.
9923	1/1/1900	PRICING ADJUSTMENT - PATIENT LIABILITY DEDUCTION APPLIED.
9926	1/1/1900	PRICING ADJUSTMENT - MANUAL PRICING APPLIED
9927	1/1/1900	PRICING ADJUSTMENT - OBSERVATION UNITS

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
9928	1/1/1900	PRICING ADJUSTMENT - AMOUNT PAID IS ZERO
9929	1/1/1900	PRICING ADJUSTMENT - ANESTHESIA PRICING APPLIED.
9932	1/1/1900	PRICING ADJUSTMENT - APRDRG PRICING APPLIED
9933	1/1/1900	PRICING ADJUSTMENT - AMBULATORY PAYMENT CLASSIFICATION (APC) PRICING APPLIED.
9934	1/1/1900	PRESCRIPTION REDUCTION APPLIED.
9935	1/1/1900	PRICING ADJUSTMENT - MAXIMUM FLAT FEE PRICING APPLIED.
9936	1/1/1900	PRICING ADJUSTMENT - MAXIMUM FLAT FEE LEVEL 2 PRICING APPLIED.
9937	1/1/1900	PRICING ADJUSTMENT - USUAL & CUSTOMARY CHARGE (UCC) FLAT FEE PRICING APPLIED.
9938	1/1/1900	PRICING ADJUSTMENT - USUAL & CUSTOMARY CHARGE (UCC) FLAT FEE LEVEL 2 PRICING APPLIED.
9939	1/1/1900	FORCE-BYPASS 5% ASSESSMENT
9940	1/1/1900	EXEMPTED FROM 5% ASSESSMENT
9941	1/1/1900	PRICING ADJUSTMENT - HOSPICE LTC PER DIEM PRICING APPLIED
9942	1/1/1900	QUANTITY REDUCED BASED ON POLICY
9943	1/1/1900	SENIORCARE COST SHARE AND/OR OTHER INSURANCE PAID AMOUNT APPLIED.
9944	1/1/1900	PRICING ADJUSTMENT - INCENTIVE PRICING
9945	1/1/1900	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	1/1/1900	PRICING ADJUSTMENT: REIMBURSEMENT AMOUNT IS THE DIFFERENCE BETWEEN THE MEDICAREALLOWED AMOUNT AND THE DMAP REIMBURSEMENT AMOUNT.
9947	1/1/1900	PRICING ADJUSTMENT: MEDICARE DEDUCTIBLE, COINSURANCE AND/OR COPAYMENT PAID IN FULL.
9948	9/1/2011	NDC WAS REIMBURSED AT AWP RATE.
9949	9/1/2011	NDC WAS REIMBURSED AT SMAC RATE.
9950	9/1/2011	NDC WAS REIMBURSED AT EMAC RATE.
9951	9/1/2011	NDC WAS REIMBURSED AT WAC RATE.
9952	9/1/2011	NDC WAS REIMBURSED AT GENERIC WAC RATE.
9953	1/1/1900	MCO ENCOUNTER DETAIL MANUALLY PRICED.
9954	1/1/1900	COST SHARE FOR ENCOUNTER PROCESSING BYPASSED.
9955	1/1/1900	MEMBER IS NOT ENROLLED IN MANAGED CARE.
9956	1/1/1900	SERVICES HAVE BEEN CARVED OUT OF MCO ENCOUNTER PROCESSING.
9957	1/1/1900	THIS SERVICE IS NOT REIMBURSABLE FOR THE MANAGED CARE ENCOUNTER CLAIM FOR THE MEMBER'S BENEFIT PLAN.
9958	1/1/1900	NOT USED - MEMBER NOT IN ENROLLED IN DMAP, THEREFORE, THE ENCOUNT CANNOT BE PROCESSED.
9959	1/1/1900	PRICING ADJUSTMENT - ALLOWED AMOUNT CUTBACK TO BILLED - DETAIL
9960	1/1/1900	NDC WAS REIMBURSED AT NADAC RATE.
9961	1/1/1990	PRICING ADJUSTMENT SET TO ZERO

Mississippi Medicaid Explanation of Benefits (EOB) Codes

EOB Code	Effective Date	Description
9962	1/1/1900	PRICING ADJUSTMENT - PROVIDER REVENUE RATE PRICING APPLIED
9963	1/1/1900	PRICING ADJUSTMENT - PROVIDER CLINIC RATE PRICING APPLIED
9964	1/1/1900	PRICING ADJUSTMENT - REVENUE MAX FEE PRICING APPLIED
9965	1/1/1900	PRICING ADJUSTMENT - OUTPATIENT PER DIEM PRICING APPLIED
9966	1/1/1900	PRICING ADJUSTMENT - OPPS PRICING APPLIED
9967	1/1/1900	HOSPICE TIER 1 AND TIER 2 RATES APPLY
9968	1/1/1900	PRICING ADJUSTMENT - HOSPICE TIER PRICING APPLIED
9969	1/1/1900	PRICING ADJUSTMENT - ALLOWED AMOUNT CUTBACK TO BILLED - HEADER
9970	1/1/1900	PRICING ADJUSTMENT - PPECC ADD-ON
9971	1/1/1900	PRICING ADJUSTMENT - NURSE PRACTITIONER CUTBACK
9972	1/1/1900	PRICING ADJUSTMENT - GROUP SCHOOL SERVICES CUTBACK
9973	1/1/1900	PRICING ADJUSTMENT - ASSISTANT SURGEON CUTBACK
9974	1/1/1900	PRICING ADJUSTMENT - CO-SURGEON CUTBACK
9975	1/1/1900	PRICING ADJUSTMENT - POSTOPERATIVE MANAGEMENT ONLY CUTBACK
9976	1/1/1900	PRICING ADJUSTMENT - SURGICAL PROCEDURE ONLY CUTBACK
9977	1/1/1900	PRICING ADJUSTMENT - MEDICALLY DIRECTED ANESTHESIA CUTBACK
9978	1/1/1900	PRICING ADJUSTMENT - NON-MEDICALLY DIRECTED ANESTHESIA CUTBACK
9979	1/1/1900	PRICING ADJUSTMENT - MULTIPLE ANESTHESIA PRICING
9980	1/1/1900	PRICING ADJUSTMENT - BILATERAL PROCEDURE ADD-ON
9981	1/1/1900	PRICING ADJUSTMENT - BILATERAL/MULTIPLE SURGERY PRICING APPLIED
9982	1/1/1900	PRICING ADJUSTMENT - OPPS BILATERAL/MULTIPLE PROCEDURE PRICING APPLIED
9983	1/1/1900	PRICING ADJUSTMENT - MULTIPLE LESION PRICING
9984	1/1/1900	PRICING ADJUSTMENT - MULTIPLE DELIVERY PRICING
9986	1/1/1900	PRICING ADJUSTMENT - MEDICAL EDUCATION ADD-ON
9987	1/1/1900	PRICING ADJUSTMENT - BENEFIT ADJUSTMENT FACTOR (BAF) APPLIED (BEFORE GTB)
9988	1/1/1900	PRICING ADJUSTMENT - BENEFIT ADJUSTMENT FACTOR (BAF) APPLIED (AFTER GTB)
9989	1/1/1900	PRICING ADJUSTMENT - 5% ASSESSMENT
9998	1/1/1900	PRICING ADJUSTMENT - CUTBACK APPLIED
9999	1/1/1900	PROCESSED PER POLICY