

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0006	The provider was not enrolled as an eligible provider on the date(s) of service. The provider should verify the date of service and the date the provider became an enrolled provider (using the Provider Turn-Around form). The claim should be rebilled if the date of provider enrollment is prior to, or on, the date of service.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Start: 1/1/95 Last Modified: 10/31/98	N95	This provider type/provider specialty may not bill this service. Note: (New code 7/31/01, Modified 2/28/03)
0007	The provider has not submitted a complete cost report or has failed to provide other documentation requested by the Department of Community Health.	OA	Other Adjustments	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 09/21/2008	N29	Missing documentation/orders/notes/summary/report/chart. Note: (Modified 2/28/03, 8/1/05) Related to N225
0011	Incomplete/invalid taxpayer identification number (TIN) submitted by you. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of TIN. You may rebill this claim after you have notified the Department of Community Health of your correct TIN.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
0013	The claim was submitted electronically and there is no authorization for this billing agent from the provider on file. The provider must associate to the Billing Agent within CHAMPS Provider Enrollment. Once MDCH has approved this association the provider may rebill the claim. Description change 9/08	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N51	Electronic interchange agreement not on file for provider/submitter. Start: 1/1/00
0014	The date of service is more than 180 days from the Julian Date of the Prior Authorization Number.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0015	The date of service is more than 180 days from the Julian Date of the Prior Authorization Number.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0019	The beneficiary ID Number is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	MA61	Missing/incomplete/invalid social security number or health insurance claim number. Note: (Modified 2/28/03)

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0020	The beneficiary ID Number is not numeric. The provider should verify the beneficiary ID Number. The claim should be corrected and rebilled.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	MA61	Missing/incomplete/invalid social security number or health insurance claim number. Note: (Modified 2/28/03)
0021	The beneficiary ID Number is invalid. The provider should verify the beneficiary ID Number. The claim should be corrected and rebilled.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	MA61	Missing/incomplete/invalid social security number or health insurance claim number. Note: (Modified 2/28/03)
0022	The beneficiary ID Number does not match any beneficiary ID Number on the Eligibility Verification System.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	MA61	Missing/incomplete/invalid social security number or health insurance claim number. Note: (Modified 2/28/03)
0023	The beneficiary was not eligible for Medicaid or Adult Benefits Waiver Program coverage on the date(s) of service.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0024	The beneficiary was not eligible for Children's Special Health Care Services Program coverage on the date(s) of service. The provider should verify the beneficiary ID Number with the Eligibility Notice. If the date of service is within the period of beneficiary eligibility, the claim should be rebilled.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0025	The beneficiary is enrolled in a Medicaid Health Plan. The provider should contact the Medicaid Health Plan for reimbursement.	CO	Contractual Obligations	24	Charges are covered under a capitation agreement/managed care plan. Start 1/1/95 Last Modified 9/30/07	N193	Specific federal/state/local program may cover this service through another payer. Note: (New Code 2/8/03)
0026	The beneficiary is eligible for Children's Special Health Care Services Program coverage on the date of service. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0027	The beneficiary is eligible for both Children's Special Health Care Services and Medicaid coverage on the date(s) of service. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0029	The beneficiary is eligible for Adult Benefits Waiver Program coverage on the date(s) of service. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0036	The beneficiary is eligible for only Maternity Outpatient Medical Services Program coverage on the date of service. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97

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0040	The principal diagnosis code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC change 10-07	MA63	Missing/incomplete/invalid principal diagnosis. Note: (Modified 2/28/03)
0041	The principal diagnosis code does not match the diagnosis file.	CO	Contractual Obligations	146	Diagnosis was invalid for the date(s) of service reported. Start: 6/30/02 Modified 9/30/07	MA63	Missing/incomplete/invalid principal diagnosis. Note: (Modified 2/28/03)
0042	The principal diagnosis code is under review for Program criteria.	CO	Contractual Obligations	B22	This payment is adjusted based on the diagnosis. Start: 1/1/95 Last Modified: 2/28/01	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0044	The other diagnosis code is under review for Program criteria.	CO	Contractual Obligations	B22	This payment is adjusted based on the diagnosis. Start: 1/1/95 Last Modified: 2/28/01	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0045	The principal diagnosis code is being manually reviewed as the beneficiary's age does not fall within the normally accepted age range for this diagnosis.	CO	Contractual Obligations	9	The diagnosis is inconsistent with the patient's age. Start: 1/1/95	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0046	The principal diagnosis code is being manually reviewed as the diagnosis is not normally acceptable for the beneficiary's gender.	CO	Contractual Obligations	10	The diagnosis is inconsistent with the patient's gender. Start 1/1/95 Last Modified 2/29/00	MA63	Missing/incomplete/invalid principal diagnosis. Note: (Modified 2/28/03)
0050	The principal diagnosis code is being manually reviewed as this type of provider does not normally render treatment for this diagnosis.	CO	Contractual Obligations	12	The diagnosis is inconsistent with the provider type. Start 1/1/95	MA63	Missing/incomplete/invalid principal diagnosis. Note: (Modified 2/28/03)
0051	The procedure code billed does not reflect the appropriate treatment for the principal diagnosis.	CO	Contractual Obligations	11	The diagnosis is inconsistent with the procedure. Start: 1/1/95	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301
0058	The procedure code billed does not reflect the appropriate treatment for the secondary diagnosis.	CO	Contractual Obligations	11	The diagnosis is inconsistent with the procedure. Start: 1/1/95	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301

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0061	The other diagnosis code does not match the diagnosis file.	CO	Contractual Obligations	146	Diagnosis was invalid for the date(s) of service reported. Start: 6/30/02 Modified 9/30/07	M64	Missing/incomplete/invalid other diagnosis. (Modified 2/28/03)
0062	The other diagnosis code is being manually reviewed as this type of provider does not normally render treatment for this diagnosis.	CO	Contractual Obligations	146	Diagnosis was invalid for the date(s) of service reported. Start: 6/30/02 Modified 9/30/07	M64	Missing/incomplete/invalid other diagnosis. (Modified 2/28/03)
0063	The other diagnosis code is being manually reviewed as the diagnosis is not normally acceptable for the beneficiary's gender.	CO	Contractual Obligations	10	The diagnosis is inconsistent with the patient's gender. Start 1/1/95 Last Modified 2/29/00	M76	Missing/incomplete/invalid diagnosis or condition. Note: (Modified 2/28/03)
0064	The other diagnosis code is being manually reviewed as the beneficiary's age does not fall within the normally accepted age range for this diagnosis.	CO	Contractual Obligations	9	The diagnosis is inconsistent with the patient's age. Start: 1/1/95	M64	Missing/incomplete/invalid other diagnosis. (Modified 2/28/03)
0065	The claim has a prior authorization number which is not yet on file with the Department of Community Health for this beneficiary, OR services on the prior authorization form have been deleted or already paid.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0066	The claim has a prior authorization number which is not yet on file with the Department of Community Health for this beneficiary, OR services on the prior authorization form have been deleted or already paid.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0067	The claim has a prior authorization number which is not yet on file with the Department of Community Health for this beneficiary, OR services on the prior authorization form have been deleted or already paid.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0073	The tooth number/letter is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC 10-07	N37	Missing/incomplete/invalid tooth number/letter. Note: (Modified 2/28/03)
0074	The tooth surface is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC 10-07	N75	Missing/incomplete/invalid tooth surface information. Note: (Modified 2/28/03)

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0075	The tooth number/letter is required. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N37	Missing/incomplete/invalid tooth number/letter. Note: (Modified 2/28/03)
0076	The tooth surface is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N75	Missing/incomplete/invalid tooth surface information. Note: (Modified 2/28/03)
0079	The injury code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	M44	Missing/incomplete/invalid condition code. Note: (Modified 2/28/03)
0080	The injury code is invalid. The injury code should be corrected and the claim should be rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	M44	Missing/incomplete/invalid condition code. Note: (Modified 2/28/03)
0087	This procedure code is being manually reviewed to determine the medical necessity and/or appropriateness of the service. The provider is required to forward the medical record for this date of service and any other documentation which supports this service to: Selective Edit Unit, Department of Community Health, P.O. Box 30479, Lansing, MI 48909. If records are not received within 30 days of the payment date of this Remittance Advice on which this explanation code first appears for this claim, the claim will be rejected.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	MA26	Alert: Our records indicate that you were previously informed of this rule. Note: (Modified 4/1/07)
0088	The Medicaid co-payment has been deducted. This explanation code is for informational purposes only.	PR	Patient's Responsibility; Revised 6-06	3	Co-payment Amount Start : 1/1/95	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97

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0089	The required procedure or revenue code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC change 10-07	M51	Missing/incomplete/invalid procedure code (s) Note: (Modified 12/2/04) Related to N301
0091	Incomplete or invalid procedure code. The claim should be corrected and rebilled.	CO	Contractual Obligations	181	Procedure code was invalid on the date of service. Start: 6/30/05 Last Modified 9/30/07	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301
0092	The procedure code is invalid, OR the combination of the type of service code and procedure code is invalid, OR the procedure code is incorrect for the provider OR for Outpatient Hospital, the required HCPCS code is missing. The provider should verify the procedure code, type of service code, and provider type code. The claim should be corrected and rebilled. OR The Hospice provider is billing for room and board, and the nursing facility provider ID Number is not correct or is missing. A new or corrected enrollment form with the correct nursing facility ID Number should be submitted to MDCH. The claim should be rebilled once MDCH has entered the correct information on its payment system.	CO	Contractual Obligations	181	Procedure code was invalid on the date of service. Start: 6/30/05 Last Modified 9/30/07	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301
0093	The procedure code or the combination of the type of service code and procedure code is not covered on the date of service. The provider should verify the procedure code, type of service code, and date of service. Provider should also verify the billing procedure with current manual material for possible changes. The claim should be corrected and rebilled.	CO	Contractual Obligations	181	Procedure code was invalid on the date of service. Start: 6/30/05 Last Modified 9/30/07	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301
0095	The place of service is not acceptable for this procedure code or type of service.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service. Start 1/1/95	M77	Missing/incomplete/invalid place of service. Note: (Modified 2/28/03)
0096	The procedure code is being manually reviewed as the beneficiary's age does not fall within the normally accepted age range for the procedure.	CO	Contractual Obligations	6	The procedure/revenue code is inconsistent with the patient's age. Start 1/1/95 Last Modified 6/30/02	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)

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0097	The procedure code is being manually reviewed as the procedure is not normally acceptable for the beneficiary's gender.	CO	Contractual Obligations	7	The procedure/revenue code is inconsistent with the patient's gender. Start 1/1/95 Last Modified 6/30/02	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301
0099	The procedure code is being manually reviewed as this type of provider does not normally render the indicated procedure.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Start 1/1/95 Last Modified 6/30/02	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0100	The amount to be paid for this procedure is being determined manually.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0101	Reimbursement for the procedure billed has been made based on Medicaid's allowable quantity. The quantity has been reduced to Medicaid's allowable quantity. The Remittance Advice indicates the quantity on which reimbursement is based. This explanation code is for informational purposes only.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/02 Last Modified 1/27/08	N362	The number of Days or Units of Service exceeds our acceptable maximum. Note: (New Code 11/18/05)
0102	The amount billed is being manually reviewed.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0104	This procedure code or drug code is being manually reviewed for Program criteria.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0105	This service may have a comprehensive/component or a mutually exclusive relationship with another service billed for the same date.	CO	Contractual Obligations	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 1/1/95 Last Modified: 9/30/07	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)

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0107	The sum of Medicare and other insurance payments equals or exceeds Medicaid's rate. This explanation code is for informational purposes only.	CO	Contractual Obligations	23	The impact of prior payer(s) adjudication including payments and/or adjustments Start: 1/1/95 Last Modified: 9/30/07	N131	Total payments under multiple contracts cannot exceed the allowance for this service. Note: (New Code 10/31/02)
0110	The Level of Care shown on the claim does not match the Level of Care on Eligibility Verification System for this beneficiary.	CO	Contractual Obligations	186	Level of care change adjustment. Start: 6/30/05 Last Modified: 9/30/07	N188	The approved level of care does not match the procedure code submitted. Note: (New Code 2/28/03)
0116	Medicare coverage may be available when a diagnosis or procedure is for chronic renal disease.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N196	Alert: Patient eligible to apply for other coverage which may be primary. Note: (New Code 2/28/03, Modified 4/1/07)
0119	The provider does not have the appropriate specialty on file with Provider Enrollment to be reimbursed for this service. This service must not be rebilled.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Start: 1/1/95 Last Modified: 6/30/02	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0121	The primary surgical procedure code does not match the procedure file. The claim should be corrected and rebilled.	CO	Contractual Obligations	181	Procedure code was invalid on the date of service. Start: 6/30/05 Last Modified: 9/30/07	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301
0122	Operating room charges were billed without a primary surgical procedure code. The claim should be corrected and rebilled.	CO	Contractual Obligations	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated Start: 1/1/95 Last Modified: 9/30/07	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301
0126	The secondary surgical procedure code does not match the procedure file. The provider should correct the secondary surgical procedure code and rebill the claim.	CO	Contractual Obligations	181	Procedure code was invalid on the date of service. Start: 6/30/05 Last Modified: 9/30/07	M67	Missing/incomplete/invalid other procedure code(s). Note: (Modified 12/2/04) Related to N302
0130	The individual consideration code is invalid. This explanation code is for informational purposes only.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	N59	Alert: Please refer to your provider manual for additional program and provider information. Note: (Modified 4/1/07)
0132	The disposition of this claim/service is pending further review.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0136	The attending physician provider ID Number is missing. The provider should enter the correct attending physician provider ID Number and rebill.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start: 01/01/1995 Last Modified: 6/30/06	N253	Missing/incomplete/invalid attending provider primary identifier. Note: (New Code 12/2/04)

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0137	The attending physician provider ID Number is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N253	Missing/incomplete/invalid attending provider primary identifier. Note: (New Code 12/2/04)
0141	This type of provider is not authorized to provide treatment under the Adult Benefits Waiver Program.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0142	The place of service is not acceptable for the Adult Benefits Waiver Program. The service must not be rebilled.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0143	The procedure or drug code is not covered for the Adult Benefits Waiver Program.	CO	Contractual Obligations	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code) Start: 1/1/95 Last Modified 6/30/06	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0147	This service is from a non-covered provider type or is not covered under the beneficiary's current plan.	CO	Contractual Obligations	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code) Start: 1/1/95 Last Modified 6/30/06	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0148	This place of service is not covered under the beneficiary's current coverage.	CO	Contractual Obligations	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code) Start: 1/1/95 Last Modified 6/30/06	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0150	Did not complete or enter accurately the referring provider ID Number. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N286	Missing/incomplete/invalid referring provider primary identifier. Note; (New Code 12/2/04)
0151	Did not complete or enter accurately the-referring provider ID Number. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC change 10-07	N286	Missing/incomplete/invalid referring provider primary identifier. Note; (New Code 12/2/04)

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EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0152	The-referring physician ID Number is being reviewed. This explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N286	Missing/incomplete/invalid referring provider primary identifier. Note: (New Code 12/2/04)
0154	The date of service is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: (Modified 2/28/03)
0155	The date of service is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: (Modified 2/28/03)
0156	The date of service is after the date the claim was received by the Department of Community Health. The date should be verified. If appropriate, the claim should be corrected and rebilled. If the date is correct, the service must not be rebilled.	CO	Contractual Obligations	110	Billing date predates service date. Start: 1/1/95	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: (Modified 2/28/03)
0157	The claim line date of service is not included in the range of dates indicated by the begin to end dates of service. If appropriate, the claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: (Modified 2/28/03)
0158	The time limit for filing has expired.	CO	Contractual Obligations	29	The time limit for filing has expired. Start: 1/1/95	N59	Alert: Please refer to your provider manual for additional program and provider information. Note: (Modified 4/1/07)
0161	The provider is a hospital-based physician. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N45	Payment based on authorized amount. Start: 1/1/00

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0162	The provider does not have the appropriate specialty on file with Provider Enrollment to be reimbursed for this procedure. The provider must submit a copy of his/her board certification or proof of completing a residency in the specialty area, along with his/her provider ID Number, to the Provider Enrollment Unit.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty. (taxonomy). Start: 1/1/95 Last Modified 6/30/02	N95	This provider type/provider specialty may not bill this service. Note: (New code 7/31/01, Modified 2/28/03)
0163	Inpatient Friday/Saturday elective admission.	CO	Contractual Obligations	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Start 1/1/95	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0164	The admission date is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA40	Missing/incomplete/invalid admission date. Note: (Modified 2/28/03)
0165	The admission date is invalid.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	MA40	Missing/incomplete/invalid admission date. Note: (Modified 2/28/03)
0166	The admission date is after the begin date of service. The date(s) should be verified. If appropriate, the claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA40	Missing/incomplete/invalid admission date. Note: (Modified 2/28/03)
0168	The provider's total charge exceeds Medicaid's rate; the Medicaid payment has been reduced due to Medicare and other insurance payments. This results in a Medicaid payment, but the amount is less than requested. This explanation code is for informational purposes only.	CO	Contractual Obligations	23	The impact of prior payer(s) adjudication including payments and/or adjustments Start 1/1/95 Last Modified 9/30/07	N219	Payment based on previous payer's allowed amount. Note: (New Code 8/1/04)
0169	The provider type on the prior authorization form on file with the Department of Community Health does not match the provider type on the claim.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0170	Provider ID # on the prior authorization (PA) does not match the provider ID # on the claim. This explanation code is for informational purposes only.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0171	The procedure code on the claim does not match the procedure code on the prior authorization form on file with the Department of Community Health.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0173	The Dental Invoice tooth number/letter does not match the tooth number/letter on the prior authorization form on file with the Department of Community Health. The provider should verify the tooth number/letter billed with the number/letter that was prior authorized. If they match, the provider should contact the dental consultant.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N37	Missing/incomplete/invalid tooth number/letter. Note: (Modified 2/28/03)
0174	The begin date of service is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	M52	Missing/incomplete/invalid "from" date(s) of service. Note: (Modified 2/28/03)
0175	The begin date of service is invalid.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M52	Missing/incomplete/invalid "from" date(s) of service. Note: (Modified 2/28/03)
0176	The begin date of service is after the end date of service. The date(s) should be verified. If appropriate, the claim should be corrected and rebilled. If the date is correct, the service must not be rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: (Modified 2/28/03)
0178	The quantity indicated on the claim is greater than the quantity indicated on the prior authorization form on file with the Department of Community Health.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N362	The number of Days or Units of Service exceeds our acceptable maximum. Note: (New Code 11/18/05)
0180	The procedure code billed has been deleted from the prior authorization form on file with the Department of Community Health.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0181	The prior authorization on file with the Department of Community Health indicates the procedure code has previously been paid. The service must not be rebilled.	CO	Contractual Obligations	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment. Start: 1/1/95	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0183	The date of service is prior to the date of the prior authorization.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0184	The end date of service is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	M59	Missing/incomplete/invalid "to" date(s) of service. Note: (Modified 2/28/03)
0185	The end date of service is invalid OR, for Outpatient Hospital, the claim line date of service is not included in the range of dates indicated by the from and through dates on the claim.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M59	Missing/incomplete/invalid "to" date(s) of service. Note: (Modified 2/28/03)
0186	The end date of service is after the date the claim was received by the Department of Community Health. The date(s) should be verified. If appropriate, the claim should be corrected and rebilled.	CO	Contractual Obligations	110	Billing date predates service date. Start: 1/1/95	M59	Missing/incomplete/invalid "to" date(s) of service. Note: (Modified 2/28/03)
0187	The range from begin to end date of service covers more than one month. The provider should rebill each month on a separate claim.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month. Start: 1/1/00
0188	There is no authorization for long-term care on Eligibility Verification System for at least one of the dates covered by this claim.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0190	Invalid prior authorization number. The claim should be corrected and rebilled.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0191	The prior authorization number does not digit-check.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0192	The provider does not have the appropriate specialty on file to be reimbursed for this procedure. If the provider has the appropriate specialty, then the Provider Enrollment Unit should be notified and the claim rebilled. If the provider does not have the appropriate specialty, then the service must not be rebilled.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Start 1/1/95 Last Modified 6/30/02	N95	This provider type/provider specialty may not bill this service. Note: (New code 7/31/01, Modified 2/28/03)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0193	The Children's Special Health Care Services Program has not authorized this date of service.	CO	Contractual Obligations	197	Precertification/authorization/notification absent. Start 10/31/06 Last Modified 9/30/07	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0194	The Children's Special Health Care Services Program has not authorized this provider type to render treatment to this child.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Start: 1/1/95 Last Modified: 10/31/98	N95	This provider type/provider specialty may not bill this service. Note: (New code 7/31/01, Modified 2/28/03)
0195	The Children's Special Health Care Services Program has not authorized this provider ID Number to render treatment to this child.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Start: 1/1/95 Last Modified: 10/31/98	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0196	This service is not covered for dates of service 7/1/09 and after. Edit description change 7/1/09	CO	Contractual Obligations	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code) Start: 1/1/95 Last Modified 6/30/06	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0197	The service requires prior authorization and the prior authorization number is not on the claim.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0201	The provider ID Number on the claim does not match the provider ID Number that was authorized to treat this beneficiary. The provider should check the ID Number and rebill using the correct provider ID number.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0205	Provider must bill other insurance carrier first for daily care.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0206	Invoice Other Insurance Code requires further documentation for daily care services.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97
0209	The vision co-payment has been deducted. This explanation code is for informational purposes only.	CO	Contractual Obligations	3	Co-payment Amount Start : 1/1/95	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0210	The required replacement claim or adjustment has an invalid original claim reference number.	CR	Correction and Reversals	107	The related or qualifying claim/service was not identified on this claim. Start: 1/1/95 Last Modified 9/30/07	M47	Missing/incomplete/invalid internal or document control number. Note: (Modified 2/28/03)
0211	The required original claim reference number is missing from the replacement claim or adjustment. The claim should be corrected and rebilled.	CR	Correction and Reversals	107	The related or qualifying claim/service was not identified on this claim. Start: 1/1/95 Last Modified 9/30/07	M47	Missing/incomplete/invalid internal or document control number. Note: (Modified 2/28/03)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0216	The Medicaid Health Plan has billed too far in advance. The date(s) should be verified. If incorrect, the claim should be corrected and rebilled.	CO	Contractual Obligations	110	Billing date predates service date. Start: 1/1/95	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: (Modified 2/28/03)
0217	The end date of service does not equal the last day of the month.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M59	Missing/incomplete/invalid "to" date(s) of service. Note: (Modified 2/28/03)
0218	The begin date of service does not equal the first day of the month.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M52	Missing/incomplete/invalid "from" date(s) of service. Note: (Modified 2/28/03)
0219	The primary surgical procedure date is invalid.	CO	Contractual Obligations	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated Start: 1/1/95 Last Modified: 9/30/07	N341	Missing/incomplete/invalid surgery date. Note: (New Code 12/2/04)
0220	The primary surgical procedure date is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated Start: 1/1/95 Last Modified: 9/30/07	N341	Missing/incomplete/invalid surgery date. Note: (New Code 12/2/04)
0229	The required emergent condition code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care. Start: 1/1/95	M44	Missing/incomplete/invalid condition code. Note: (Modified 2/28/03)
0230	The emergent condition code is invalid.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care. Start: 1/1/95	M44	Missing/incomplete/invalid condition code. Note: (Modified 2/28/03)
0233	The referral code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA42	Missing/incomplete/invalid admission source. Note: (Modified 2/28/03)
0234	The referral code is invalid.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	MA42	Missing/incomplete/invalid admission source. Note: (Modified 2/28/03)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0235	The provider ID Number and the procedure code billed are not compatible.	CO	Contractual Obligations	8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Start: 1/1/95 Last Modified 6/30/02	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider. Note: (Modified 2/28/03)
0236	The beneficiary was not enrolled in a Medicaid Health Plan on the date(s) of service.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	N52	Patient not enrolled in the billing provider's managed care plan on the date of service. Start: 1/1/00
0241	The claim line was billed with modifiers indicating the service is not covered by Medicare.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start: 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start: 1/1/97
0243	The coordination of benefits indicator or the Medicare status code is invalid as it does not match the payment, deductible or coinsurance information entered on the claim.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start: 01/01/1995 Last Modified 6/30/06	N245	Incomplete/invalid plan information for other insurance. Note: (New code 8/1/04)
0244	The claim is being reviewed for possible Medicare coverage.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N196	Alert: Patient eligible to apply for other coverage which may be primary. Note: (New Code 2/28/03, Modified 4/1/07)
0245	The claim is being reviewed for possible Medicare coverage.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N196	Alert: Patient eligible to apply for other coverage which may be primary. Note: (New Code 2/28/03, Modified 4/1/07)
0247	The beneficiary is age 65 or older and there is no indication that Medicare has made payment or applied the charge to the beneficiary's deductible.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N196	Alert: Patient eligible to apply for other coverage which may be primary. Note: (New Code 2/28/03, Modified 4/1/07)
0252	The modifier or the type of service submitted on this claim is inconsistent with authorized services.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0253	Wrong procedure code system is being billed.	CO	Contractual Obligations	181	Procedure code was invalid on the date of service. Start: 6/30/05 Last Modified 9/30/07	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301
0258	Invalid relationship between claim line COB value and claim line payment OR invalid relationship between COB values and total insurance paid.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start: 1/1/95 Last Modified 10/31/06	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start: 1/1/97

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0262	The beneficiary data on the Eligibility Verification System indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97
0264	The discharge status code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA43	Missing/incomplete/invalid patient status. Note: (Modified 2/28/03)
0265	The discharge status code is invalid.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	MA43	Missing/incomplete/invalid patient status. Note: (Modified 2/28/03)
0269	The claim is being manually reviewed for possible change in other insurance status.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0271	The Medicaid Health Plan beneficiary has other insurance. This explanation code is for informational purposes only.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0280	The surgeon's provider ID Number is invalid.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N262	Missing/incomplete/invalid operating provider primary identifier. Note: (New code 12/2/04)
0282	The beneficiary-pay amount does not agree with the data on the Eligibility Verification System for this date of service. The beneficiary-pay amount for this beneficiary should be verified by the provider before billing another claim for this beneficiary. The explanation code is for informational purposes only.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)
0284	State-owned and -operated facilities are not allowed to offset beneficiary-pay amounts. The service must not be rebilled.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0294	There is an invalid relationship between the claim line date of service and the number of days/quantity. The claim should be corrected and rebilled.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/02 Last Modified 1/27/08	N345	Date range not valid with units submitted. Note: (New Code 3/30/05)
0299	Ancillary services may not be billed to Medicaid by state-owned and -operated ICF MR (Provider Type 65) facilities. The claim should not be rebilled.	CO	Contractual Obligations	171	Payment is denied when performed/billed by this type of provider in this type of facility. Start 6/30/05	N95	This provider type/provider specialty may not bill this service. Note: (New code 7/31/01, Modified 2/28/03)
0301	The relationship between the Adjustment Code (Type of Bill indicator) and the Original Claim Reference Number is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M47	Missing/incomplete/invalid internal or document control number. Note: (Modified 2/28/03)
0302	Outpatient services for beneficiaries in a long-term care facility are limited to ancillary services. The service must not be rebilled.	CO	Contractual Obligations	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start 1/1/95 Last Modified 9/30/07	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0310	The service is included in the long-term care facility's per diem rate.	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents. Note: (Modified 6/30/03)
0313	The last date of service cannot be a therapeutic leave day.	CO	Contractual Obligations	B7	Provider was not certified/eligible to be paid for this procedure/service on this date of service. Start 1/1/95 Last Modified 10/31/98	M59	Missing/incomplete/invalid "to" date(s) of service. Note: (Modified 2/28/03)
0317	The relationship between the beneficiary's Level of Care and the provider type is invalid.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Start: 1/1/95 Last Modified: 10/31/98	N95	This provider type/provider specialty may not bill this service. Note: (New code 7/31/01, Modified 2/28/03)
0321	The procedure is being reviewed as a separate procedure.	CO	Contractual Obligations	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 1/1/95 Last Modified: 9/30/07	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0323	Multiple procedures are being reviewed for appropriate reimbursement.	CO	Contractual Obligations	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 1/1/95 Last Modified: 9/30/07	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0325	Multiple procedures are being reviewed for appropriate reimbursement.	CO	Contractual Obligations	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 1/1/95 Last Modified: 9/30/07	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0327	The appropriate CLIA lab specialty code is not on the Provider Enrollment file. The provider should notify Provider Enrollment, in writing, of its CLIA certification. The claim must not be rebilled until the Provider Enrollment file is updated.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Start: 1/1/95 Last Modified: 10/31/98	MA120	Missing/incomplete/invalid CLIA certification number. Note: (Modified 2/28/03)
0328	The beneficiary is eligible for only Children's Special Health Care Services Program coverage and the service billed is not a benefit of that program. The service should not be rebilled.	CO	Contractual Obligations	204	This service/equipment/drug is not covered under the patient's current benefit plan. Start: 2/28/07	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0329	The number of days or visits is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC change 10-07	M53	Missing/incomplete/invalid days or units of service. Note: (Modified 2/28/03)
0332	The number of days billed in the From and Through dates does not equal the number of total days on the claim lines.	CO	Contractual Obligations	152	Payer deems the information submitted does not support this length of service. Start: 10/31/02 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0333	This procedure code cannot be used by this provider. The service should not be rebilled.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Start: 1/1/95 Last Modified: 10/31/98	N95	This provider type/provider specialty may not bill this service. Note: (New code 7/31/01, Modified 2/28/03)
0337	The compounded indicator was changed to 1, as the value submitted was invalid. Valid values are 4 (home infusion therapy), 3 (compound for capsules, suppositories, and tissue papers), 2 (compound for other forms) and 1 (not a compound). The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0338	The procedure code requires prior authorization when billed with this diagnosis.	CO	Contractual Obligations	B22	This payment is adjusted based on the diagnosis. Start 1/1/95 Last Modified 2/28/01	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0339	Replacement claim or adjustment pending for determination of compliance with prior authorization requirements.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N377	Payment based on a processed replacement claim. Start: 12/1/06 Last Modified: 11/5/07 Note: (Modified 11/5/07)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0342	A unit dose fee has been approved for this provider. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0343	This procedure is being manually reviewed for identification of the referring/attending provider. This explanation code is for informational purposes only.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N55	Procedure for billing with the group/referring/performing providers were not followed. Start: 1/1/00
0344	Required referring/attending provider ID Number is missing or invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N286	Missing/incomplete/invalid referring provider primary identifier. Note: (New Code 12/2/04)
0348	This service has been reimbursed as a bilateral procedure based on the reporting of Modifier Code 50. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0349	Modifier Code 50 has been reported for this procedure, but no additional reimbursement has been made. This explanation code is for informational purposes only.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start 1/1/95	M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code. Note: (Modified 2/1/04)
0350	Required place of service code is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC change 10-07	M77	Missing/incomplete/invalid place of service. Note: (Modified 2/28/03)
0355	Required quantity billed is invalid or missing.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC change 10-07	M53	Missing/incomplete/invalid days or units of service. Note: (Modified 2/28/03)
0364	The service has been rejected as it was rendered upon an order/prescription from a suspended provider. The claim must not be rebilled.	CO	Contractual Obligations	184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Start: 6/30/05	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0368	Other insurance has reduced the amount approved to zero. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N131	Total payments under multiple contracts cannot exceed the allowance for this service. Note: (New Code 10/31/02)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0372	The National Drug Code (NDC) billed is not applicable for the beneficiary's gender. All data should be verified. If appropriate, corrections should be made and the claim rebilled. If the data is correct, the service must not be rebilled. Description change 10-07	CO	Contractual Obligations	7	The procedure/revenue code is inconsistent with the patient's gender. Start 1/1/95 Last Modified 6/30/02	M119	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC). Note: (Modified 2/28/03, 4/1/04)
0378	The new/refill code is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code) Start 1/1/95 Last Modified 4/1/07 Description Change	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: (Modified 2/28/03)
0379	The fee for this procedure is being manually reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0381	The facility charge is invalid.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M79	Missing/incomplete/invalid charge. Note: (Modified 2/28/03)
0382	The quantity times the rate does not equal the hospital charge.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0383	The professional charge is missing. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code) Start 1/1/95 Last Modified 4/1/07 Description Change	M79	Missing/incomplete/invalid charge. Note: (Modified 2/28/03)
0384	The professional charge is invalid. The claim should be corrected and rebilled.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M79	Missing/incomplete/invalid charge. Note: (Modified 2/28/03)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0388	The diagnosis code does not appear to support the procedure billed.	CO	Contractual Obligations	11	The diagnosis is inconsistent with the procedure. Start: 1/1/95	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0389	There is an invalid relationship between the number of days billed, the from and through dates, and the discharge status code.	CO	Contractual Obligations	152	Payer deems the information submitted does not support this length of service. Start: 10/31/02 Last Modified 9/30/07	N50	Missing/incomplete/invalid discharge information. Note: (Modified 2/28/03)
0390	The other insurance payment on this claim line is invalid.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97
0396	The charges minus Medicare and other insurance payment(s) do not equal the amount billed. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers. Start: 1/1/97
0397	The charges, minus Medicare and other insurance payment(s), do not equal the amount billed.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0398	Number of claim lines greater than 1.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N63	Rebill services on separate claim lines. Start: 1/1/00
0400	The total number of lines is invalid. This explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N63	Rebill services on separate claim lines. Start: 1/1/00
0401	The total number of lines is missing. This explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0403	The data on the Eligibility Verification System indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled using the correct other insurance code and documentation.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0404	The claim is being manually reviewed for possible change in other insurance status.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0407	The data on the Eligibility Verification System indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled using the correct other insurance code and documentation.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0408	The claim is being manually reviewed for possible change in other insurance status.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0409	The data on the Eligibility Verification System indicates other insurance. The provider should investigate to determine if benefits are available. The claim should be rebilled using the correct other insurance code and documentation.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0410	The Medicare payment is invalid.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N48	Claim information does not agree with information received from other insurance carrier. Start: 1/1/00
0411	The claim is being manually reviewed for possible change in other insurance status.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0415	COB deductible/co-ins is missing or invalid.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N48	Claim information does not agree with information received from other insurance carrier. Start: 1/1/00
0416	The amount billed as Medicare coinsurance is not calculated correctly based on the total Medicare payment.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N48	Claim information does not agree with information received from other insurance carrier. Start: 1/1/00
0420	The amount applied to the Medicare deductible exceeds the yearly Medicare deductible.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N48	Claim information does not agree with information received from other insurance carrier. Start: 1/1/00

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0422	A hospital charge is not allowed for this procedure, or the procedure performed is not indicated on the claim.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service. Start 1/1/95	M51	Missing/incomplete/ invalid procedure code(s). Note: (Modified 12/2/04) Related to N301
0423	The procedure code cannot be billed by the Outpatient Hospital. The provider must rebill using the correct claim form.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service. Start 1/1/95	N34	Incorrect claim form/format for this service. Note: (Modified 11/18/05)
0424	This procedure code supports the hospital charge codes; no charge is allowed. This explanation code is for informational purposes only.	CO	Contractual Obligations	185	The rendering provider is not eligible to perform the service billed. Start: 6/30/05	N365	This procedure code is not payable. It is for reporting/information purposes only. Note: (New Code 4/1/06)
0425	The total other insurance paid is invalid.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	N245	Incomplete/invalid plan information for other insurance. Note: (New code 8/1/04)
0426	Beneficiary not eligible for Medicaid and not covered for ABW because of county of residence. The provider should contact the beneficiary's health care or dental contractor.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. Start: 1/1/95	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0432	The quantity billed is missing or invalid, or the outpatient hospital has asked for individual consideration.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/02 Last Modified 1/27/08	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0433	The total charge is invalid or missing.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0434	The total Medicare payment is not numeric.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0435	The total facility charge is invalid.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0436	The sum of the total charges of each Revenue Code does not equal the total charges.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0437	The sum of the claim line charges does not equal the total charge.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0439	The sum of the other insurance payments does not equal the total insurance payments	CO	Contractual Obligations	45	Charges exceed fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 6/1/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0441	The sum of the professional charges does not equal the total professional charge.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0447	The beneficiary is a Qualified Medicare Beneficiary. This code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N192	Patient is a Medicaid/Qualified Medicare Beneficiary. Note: (New Code 2/28/03)
0448	Medicaid is liable only for the coinsurance and deductible portion of a Medicare-covered service for Qualified Medicare Beneficiaries. The claim must not be rebilled to Medicaid.	CO	Contractual Obligations	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code) Start: 1/1/95 Last Modified 6/30/06	N192	Patient is a Medicaid/Qualified Medicare Beneficiary. Note: (New Code 2/28/03)
0450	The beneficiary-pay amount is invalid.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)
0452	The claim is pending for manual review of the beneficiary-pay amount.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)
0454	This service is not covered by the Program. The service must not be rebilled.	CO	Contractual Obligations	204	This service/equipment/drug is not covered under the patient's current benefit plan. Start: 2/28/07	N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0462	The beneficiary is only eligible for emergency services and elective services have been billed. The service must not be rebilled.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care. Start: 1/1/95	N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008
0463	The primary physician's ID Number is not the same as the billing provider's ID Number or the referring/attending provider's ID Number on the claim. The provider should verify that the provider ID Number used on the claim is the primary physician's ID Number.	CO	Contractual Obligations	38	Services not provided or authorized by designated (network/primary care) providers. Start 1/1/95 Last Modified 6/30/03	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: (New code 12/2/04)
0465	The total amount billed is invalid.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0468	The summary of the charges does not agree with the total amount billed.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)
0472	The Physician Sponsor's/Clinic Plan's Medicaid provider ID Number is not the same as the attending physician's provider ID Number on the claim. The provider should verify the attending physician's provider ID Number on the claim. If the number on the claim is incorrect, the provider should correct and rebill the claim. If the beneficiary was referred for medical care, the attending physician's provider ID Number must indicate the Physician Sponsor's/Clinic Plan's provider ID Number on the claim when billing. Medicaid will not cover services rendered to a Physician Sponsor/Clinic Plan beneficiary without the Physician Sponsor's/Clinic Plan's authorization unless the services were in response to an emergency situation.	CO	Contractual Obligations	38	Services not provided or authorized by designated (network/primary care) providers. Start 1/1/95 Last Modified 6/30/03	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: (New code 12/2/04)
0474	The beneficiary is enrolled in the Beneficiary Monitoring Restricted Provider Control Program and the provider ID Number is not the same as the provider or referring/attending/prescribing provider ID Number on the claim.	CO	Contractual Obligations	38	Services not provided or authorized by designated (network/primary care) providers. Start 1/1/95 Last Modified 6/30/03	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: (New code 12/2/04)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0483	The beneficiary-pay amount has been corrected to match the amount on the Medicaid Eligibility File. If an insufficient beneficiary-pay amount has been collected, the balance is due from the beneficiary. If an excessive amount has been collected, the balance is due to the beneficiary. The explanation code is for informational purposes only.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)
0486	The beneficiary no longer resides in the Medicaid Health Plan service area.	CO	Contractual Obligations	180	Patient has not met the required residency requirements.. Start 6/30/05 Last Modified 9/30/07	N52	Patient not enrolled in the billing provider's managed care plan on the date of service. Start: 1/1/00
0488	The Children's Special Health Care Services Program has not authorized this provider type to render services to this child.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Start: 1/1/95 Last Modified: 10/31/98	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0489	The beneficiary is not eligible for Medicaid Health Plan enrollment.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	N52	Patient not enrolled in the billing provider's managed care plan on the date of service. Start: 1/1/00
0492	The beneficiary was not eligible for Children's Special Health Care Services, Medicaid, State Medical Program, or Resident County Hospitalization coverage on the date(s) of service. The date(s) and beneficiary ID Number should be verified. If appropriate, the claim should be corrected and rebilled. If the data is correct, the service must not be rebilled.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0494	The beneficiary was determined ineligible for Medical Assistance after a Medicaid ID Card was issued. Since a card was issued, the claim has been processed for payment. This also applies to the Adult Benefits Waiver Program in those counties where an ID Card is issued. The explanation code is for informational purposes only.	CO	Contractual Obligations	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Start 1/1/95 Last Modified 10/31/98	M17	Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions. Note: (Modified 4/1/07)
0495	The beneficiary is over one year of age and is not enrolled in a Medicaid Health Plan or clinic plan on the date of service.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	N52	Patient not enrolled in the billing provider's managed care plan on the date of service. Start: 1/1/00
0497	This claim line is paid at 50% of the provider's charge or at 50% of Medicaid reimbursement, whichever is less. The explanation code is for informational purposes only.	CO	Contractual Obligations	172	Payment is adjusted when performed/billed by a provider of this specialty. Start: 6/30/05	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0498	This service must be billed with a modifier. The claim should be rebilled with the appropriate modifier.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	M20	Missing/incomplete/invalid HCPCS. Note: (Modified 2/28/03)
0500	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	CO	Contractual Obligations	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 1/1/95 Last Modified: 9/30/07	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0501	Duplicate procedure between HCPCS and old procedure coding.	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95	M84	Medical code sets used must be the codes in effect at the time of service. Note: (Modified 2/1/04)
0503	The date of service on the claim requires manual review. Adjustments will be processed manually.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0504	Date of claim is too old for immediate computer processing.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0505	The dates of service span two or more historical processing periods. Each date of service must be rebilled on a separate claim.	CO	Contractual Obligations	141	Claim spans eligible and ineligible periods of coverage. Start 6/30/99 Last Modified 9/30/07	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: (Modified 2/28/03)
0506	The services do not reflect the provision of nursing or physical therapy services.	CO	Contractual Obligations	150	Payer deems the information submitted does not support this level of service. Start 10/31/02 Modified 9/30/07	N320	Missing/incomplete/invalid Home Health Certification Period. Note: (New Code 12/2/04)
0508	Date of Service for Medicaid Health Plan (MHP) claim is too old to be processed.	CO	Contractual Obligations	95	Plan procedures not followed. Start: 1/1/95 Last Modified: 9/30/07	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: (Modified 2/28/03)
0510	The claim indicates a possible DRG overpayment.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N45	Payment based on authorized amount. Start: 1/1/00
0511	The claim indicates an admission to the hospital within 15 days of discharge from a different hospital.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N47	Claim conflicts with another inpatient stay. Start: 1/1/00
0513	The claim indicates a readmission to the same hospital within 15 days of discharge. The claim should be rebilled as explained in the Medicaid Hospital Manual.	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	N47	Claim conflicts with another inpatient stay. Start: 1/1/00

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0515	The outpatient claim indicates emergency room services (Revenue code 450) and subsequent admission to the inpatient hospital setting.	CO	Contractual Obligations	60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services Start: 1/1/95 Last Modified 1/1/09	N47	Claim conflicts with another inpatient stay. Start: 1/1/00
0518	This beneficiary was admitted/hospitalized within 15 days of discharge from a different hospital.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N47	Claim conflicts with another inpatient stay. Start: 1/1/00
0530	The outpatient claim is for services provided during an inpatient stay. These outpatient services must be included on the inpatient claim. The outpatient hospital must contact the inpatient hospital for reimbursement for these services.	CO	Contractual Obligations	60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services Start: 1/1/95 Last Modified 1/1/09	MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay. Start 10/12/01
0532	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure. Start: 1/1/97
0534	The total of the beneficiary-pay amount on all long-term care invoices for this beneficiary for this month of service exceeds the beneficiary-pay amount shown on the Eligibility Verification System. This explanation code is for informational purposes only. The provider should refund the excess beneficiary-pay amount to the beneficiary and submit a claim adjustment.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)
0535	The total of the beneficiary-pay amount on all long-term care invoices for this beneficiary for this month of service is less than the beneficiary-pay amount shown on the Eligibility Verification System. The Department of Community Health has corrected the beneficiary-pay amount on this claim to reflect the beneficiary-pay amount shown on the Eligibility Verification System for the month.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)
0536	The amount billed for this laboratory service exceeds the dollar limitation established by the Program.	CO	Contractual Obligations	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 09/21/2008	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0538	The amount billed for this laboratory service exceeds the dollar limitation established by the Program.	CO	Contractual Obligations	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 09/21/2008	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0540	Beneficiary enrolled in Healthy Kids Dental Program. Submit claim to the dental carrier. Do not rebill the Medicaid Program.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. Start: 1/1/95	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0544	Physician ER case rate: services provided in an emergency room, and subject to the ER case rate payment, have been billed on separate invoices. This claim has been pended for review.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	M85	Subjected to review of physician evaluation and management services. Start: 1/1/97
0545	Rental converted to purchase.	CO	Contractual Obligations	108	Rent/purchase guidelines were not met. Start: 1/1/95 Last Modified: 9/30/07	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price. Start 1/1/97
0548	The claim is a duplicate of a previously paid claim. The Claim Reference Number, line number, and payment date of the paid claim are shown. (If the Claim Reference Number following Explanation Code 548 is the same as the number assigned to this claim in the left column on the Remittance Advice, duplicate services are billed on this claim.)	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: (Modified 6/30/03)
0549	The claim is a duplicate of a claim paid to another Medicaid Health Plan.	CO	Contractual Obligations	24	Charges are covered under a capitation agreement/managed care plan. Start 1/1/95 Last Modified 9/30/07	N193	Specific federal/state/local program may cover this service through another payer. Note: (New Code 2/8/03)
0552	The claim is a duplicate of a previously paid claim. The Claim Reference Number, line number, and payment date of the paid claim are shown. (If the Claim Reference Number following Explanation Code 552 is the same as the number assigned to this claim in the left column on the Remittance Advice, duplicate services are billed on this claim.)	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: (Modified 6/30/03)
0553	The frequency of this service is being manually reviewed.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/02 Last Modified 1/27/08	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met. Note: (New Code 11/18/05)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0555	The date(s) of service is invalid.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N301	Missing/incomplete/invalid procedure dates(s). Note: (New Code 12/2/04)
0560	A claim is on file with a different drug entity for the same beneficiary and prescription number. The explanation code is for informational purposes only.	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95	N45	Payment based on authorized amount. Start: 1/1/00
0567	The beneficiary has received the same drug from two different pharmacies within a short period of time. The explanation code is for informational purposes only.	CO	Contractual Obligations	20	This injury/illness is covered by the liability carrier. Start: 1/1/95 Last Modified 9/30/07	N35	Program integrity/utilization review decision. Start: 1/1/00
0571	The dates of service for this inpatient claim overlap the dates of service for another paid claim and the amounts billed are equal.	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95	N47	Claim conflicts with another inpatient stay. Start: 1/1/00
0572	This is a duplicate claim paid to the same Medicaid Health Plan for the same beneficiary and the same date(s) of service. The Claim Reference Number and payment date of the paid claim are shown. (If the Claim Reference Number following Explanation Code 572 is the same as the number assigned to this claim in the left column on the Remittance Advice, duplicate services are billed on this claim.) The service must not be rebilled.	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: (Modified 6/30/03)
0574	The Medicaid Health Plan invoice dates of service overlap the dates of the previously paid claim to another type of provider.	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: (Modified 6/30/03)
0575	The dates of services for this claim are duplicate or overlapping the dates of service for another paid claim.	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95	N20	Service not payable with other service rendered on the same date. Start: 1/1/00
0576	The payment of this Medicare deductible would result in overpayment of the Medicare deductible for the year.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0577	More than 18 therapeutic leave days have been used in the last 365 days.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	N43	Bed hold or leave days exceeded. Start: 1/1/00
0578	Billing for more than ten (10) Hospital Leave days.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N43	Bed hold or leave days exceeded. Start: 1/1/00

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0579	The sum of all beneficiary-pay amounts accumulated by this payment system, for this beneficiary, for this month of service, does not equal the beneficiary-pay amount on the system. This explanation code applies to claim adjustments only. If the claim is rejected, correct the beneficiary's patient-pay amount and rebill the adjustment. This explanation code is for informational purposes only.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)
0581	The claim to be adjusted/replaced cannot be located as a paid claim for this beneficiary.	CO	Contractual Obligations	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment. Start: 1/1/95	N152	Missing/incomplete/invalid replacement claim information. Note: (New Code 10/31/02)
0582	An attempt was made to adjust/replace a Claim Reference Number which has already been adjusted/replaced. Only the last paid Claim Reference Number can be adjusted. The claim adjustment should be rebilled using the last paid Claim Reference Number.	CO	Contractual Obligations	129	Prior processing information appears incorrect. Start 2/28/97 Last Modified 9/30/07	N152	Missing/incomplete/invalid replacement claim information. Note: (New Code 10/31/02)
0584	This is the Claim Reference Number of the claim being adjusted/replaced. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA67	Correction to a prior claim. Start 1/1/97
0589	This fiscal year has been final gross adjusted.	CO	Contractual Obligations	121	Indemnification adjustment - compensation for outstanding member responsibility Start 1/1/95 Modified 9/30/07	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0592	Duplicate claims between group ID's.	CO	Contractual Obligations	B20	Procedure/service was partially or fully furnished by another provider. Start 1/1/95 Last Modified 9/30/07	N55	Procedure for billing with the group/referring/performing providers were not followed. Start: 1/1/00
0593	More than one provider from a group has billed for this service, exceeding frequency limitations.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/02 Last Modified 1/27/08	N55	Procedure for billing with the group/referring/performing providers were not followed. Start: 1/1/00
0596	More than one provider type has billed for case management for the same month. The explanation code is for informational purposes only.	CO	Contractual Obligations	B20	Procedure/service was partially or fully furnished by another provider. Start 1/1/95 Last Modified 9/30/07	N59	Alert: Please refer to your provider manual for additional program and provider information. Note: (Modified 4/1/07)
0601	This service may have a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.	CO	Contractual Obligations	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 1/1/95 Last Modified: 9/30/07	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0602	This service has a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	M80	Not covered when performed during the same session/date as a previously processed service for the patient. Note: (Modified 10/31/02)
0603	This service may have a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.	CO	Contractual Obligations	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 1/1/95 Last Modified: 9/30/07	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0604	This service has a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	M80	Not covered when performed during the same session/date as a previously processed service for the patient. Note: (Modified 10/31/02)
0606	Multiple procedures or services have been billed on separate claims.	CO	Contractual Obligations	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated Start: 1/1/95 Last Modified: 9/30/07	M80	Not covered when performed during the same session/date as a previously processed service for the patient. Note: (Modified 10/31/02)
0607	The frequency of the combination of services billed exceeds Program policy limits. The services must not be rebilled.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: (Modified 6/30/03)
0608	The frequency of the combination of services billed exceeds Program Policy Limits. Medical necessity must be documented.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/02 Last Modified 1/27/08	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0630	Submission of duplicate value code.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	M49	Missing/incomplete/invalid value code(s) or amount(s). Note: (Modified 2/28/03)
0633	Out of state provider is not billing for emergency services, Medicare coinsurance/deductibles or prior authorized services	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care. Start: 1/1/95	N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0634	The referring provider NPI is either invalid or missing.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N286	Missing/incomplete/invalid referring provider primary identifier. Note: (New Code 12/2/04)
0635	The attending provider NPI is either invalid or missing.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N253	Missing/incomplete/invalid attending provider primary identifier. Note: (New Code 12/2/04)
0636	The attending provider NPI is either invalid or missing.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N290	Missing/incomplete/invalid rendering provider primary identifier. Note: (New Code 12/2/04)
0638	Invalid TOB. This explanation code is for informational purposes only.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service Start 1/1/95	MA30	Missing/incomplete/invalid type of bill. Note: (Modified 2/28/03)
0639	NPI reported on the claim is missing, invalid, or fails to crosswalk to a Medicaid legacy provider ID number.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: (New code 12/2/04)
0651	The amount approved has been reduced due to maximum fee screens. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0652	Service line or claim rejection has reduced the amount approved to zero. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0653	The hospital claim's DRG has caused the amount approved to be greater than the charges. This explanation code is for informational purposes only.	CO	Contractual Obligations	94	Processed in excess of charges. Start 1/1/95	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0654	The hospital claim's DRG, per diem, or percent of charge reimbursement is less than the charges. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0655	The amount approved is reduced due to the patient payment. This explanation code is for informational purposes only.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0656	The amount approved is reduced due to the other insurance and Medicare payments on the claim. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0666	Date of death is before the date of service.	CO	Contractual Obligations	13	The date of death precedes the date of service. Start: 1/1/95	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0667	Service not covered because beneficiary was incarcerated on the date of service.	CO	Contractual Obligations	177	Patient has not met the required eligibility requirements. Start: 6/30/05 Last Modified 9/30/07	N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt. Note: (Modified 6/30/03)
0668	The Claim Adjustment Reason Codes supplied by the prior payer have caused the reimbursement amount to be affected (this code will not be reported on the 835).	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0669	Claim is being adjusted because the date of service is after the date of death. This explanation code is for informational purposes only.	CO	Contractual Obligations	13	The date of death precedes the date of service. Start: 1/1/95	M17	Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions. Note: (Modified 4/1/07)
0670	Beneficiary has private coverage through a managed care organization (MCO). You must bill that MCO before payment can be considered from Medicaid. This explanation code is for informational purposes only.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0671	The insurance carrier indicates that you are a participating provider and have agreed to accept their payment as payment in full. Medicaid and CSHCS will not make further payment and the client may not be billed.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement. Start: 1/1/00

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0672	The beneficiary has met their private insurance co-pay requirement limit for the year. You may bill and receive full reimbursement from the insurance carrier. This explanation code is for informational purposes only.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0673	This service is a covered benefit under the private insurance policy of the beneficiary but, to be reimbursed, it requires you to bill the insurance carrier using a more specific diagnosis. This explanation code is for informational purposes only.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	M81	You are required to code to the highest level of specificity. Note: (Modified 2/1/04)
0674	This service is a covered benefit under the private insurance policy of the beneficiary. Bill the insurance carrier. This explanation code is for informational purposes only.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0675	The reason the insurance carrier rejected this claim is not clear. Re-bill with a copy of the EOB or include a detailed rejection description. This explanation code is for informational purposes only.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N4	Missing/incomplete/invalid prior insurance carrier EOB. Note: (Modified 2/28/03)
0676	The insurance carrier included payment for this service in another procedure performed on the same day. Re-bill both procedures reflecting the appropriate distribution of the insurance payment. This explanation code is for informational purposes only. Added explanation statement 10-07	CO	Contractual Obligations	107	The related or qualifying claim/service was not identified on this claim. Start: 1/1/95 Last Modified 9/30/07	N48	Claim information does not agree with information received from other insurance carrier. Start: 1/1/00
0677	The beneficiary has a point of service insurance policy. Medicaid requires that the beneficiary use the highest level of benefit available (e.g. using a network provider rather than paying a higher co-pay). Medicaid will not make further payment for this service. This explanation code is for informational purposes only.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0679	The service was denied by the insurance carrier for a pre-existing condition. Sufficient credible coverage exists under the Medicaid and/or CSHCS Programs to require the carrier to pay for the service. This explanation code is for informational purposes only.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00

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EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0680	Claim adjusted because client was incarcerated during the date of service This explanation code is for informational purposes only.	CO	Contractual Obligations	101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start 1/1/95 Last Modified 2/28/99	N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt. Note: (Modified 6/30/03)
0682 - 0683	This claim is rejected because: The electronic Michigan Medicaid Nursing Facility Level of Care (LOC) Determination electronic assessment was not found for this beneficiary, or the LOC Determination was done, but the beneficiary was determined not eligible for nursing facility level of services, or the LOC Determination was done, but not within 14 days of admission, or the screening was done, but the facility did not enter the beneficiary's Medicaid ID number in the on-line LOC Determination. In this case, the facility can enter the ID number in the on-line LOC Determination by going to the Determination Welcome Screen, select "ADD BENEFICIARY ID" and then rebill the claim. EXPL Code 682/683 description combined 10-07	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N146	Missing screening document. Note: (Modified 8/1/04) Related to N243
0690	This claim has been re-entered/created by the Department of Community Health. This explanation code is for informational purposes only.	CO	Contractual Obligations	101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start 1/1/95 Last Modified 2/28/99	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0691	This claim has been re-entered/created by the Department of Community Health. This explanation code is for informational purposes only.	CO	Contractual Obligations	101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start 1/1/95 Last Modified 2/28/99	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0696	The beneficiary's eligibility has been manually reviewed. This explanation code is for informational purposes only.	CO	Contractual Obligations	141	Claim spans eligible and ineligible periods of coverage. Start 6/30/99 Last Modified 9/30/07	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0700	The reimbursement amount was manually determined. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0701	A portion or all of the outlier days have been denied. The claim has been adjusted accordingly.	CO	Contractual Obligations	69	Day outlier amount. Start: 1/1/95	MA32	Missing/incomplete/invalid number of covered days during the billing period. Note: (Modified 2/28/03)
0702	The quantity has been corrected to correspond with the procedure code description and submitted documentation. In the future, the quantity field must be completed with the correct quantity. This explanation code is for informational purposes only. OR The quantity of visits has been changed to reflect those on the submitted beneficiary care plan of treatment. For payment to be considered for additional visits, a claim adjustment is required with documentation supporting the necessity for the additional visits.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/02 Last Modified 1/27/08	N22	This procedure code was added/changed because it more accurately describes the services rendered. Note: (Modified 10/31/02, 2/28/03)
0703	Medicaid is only responsible for the Medicare 20% coinsurance amount for those beneficiaries eligible for Medicare Part B for a total amount not to exceed Medicaid's reimbursement limitation. The claim has been processed for this amount up to Medicaid's maximum limitation. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0704	The maximum allowance for this service has been paid. For inpatient hospitals, any change in the charges will be manually reflected in the final settlement data. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA46	The new information was considered however, additional payment cannot be issued. Please review the information listed for the explanation. Start 1/1/97
0705	A computational error has been corrected and the total amount billed has been processed accordingly. This explanation code is for informational purposes only.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0706	For Inpatient Hospital: The beneficiary's patient-pay amount, according to the Eligibility Verification System, is less than the amount reflected on the claim. If you have collected an inappropriate beneficiary-pay amount, the difference should be refunded to the beneficiary. The explanation code is for informational purposes only. For Long-Term Care: The total of the beneficiary-pay amount on all long-term care invoices for this beneficiary for this month of service is less than the beneficiary-pay amount on the Eligibility Verification System. The Department of Community Health has corrected the beneficiary-pay amount on this claim to reflect the beneficiary-pay amount shown on the Eligibility Verification System for the month.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)
0707	The service on this claim line has been recoded to the correct procedure/type/drug code. The provider must use the corrected code for future billings. This explanation code is for informational purposes only.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	N22	This procedure code was added/changed because it more accurately describes the services rendered. Note: (Modified 10/31/02, 2/28/03)
0708	The utilization review sheet, discharge summary, anesthesia report, or admission history and physical was either not received or incomplete. The claim should be rebilled with the appropriate documentation	CO	Contractual Obligations	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 09/21/2008	N29	Missing documentation/orders/notes/summary/report/chart. Note: (Modified 2/28/03, 8/1/05) Related to N225
0709	A PACER number must be obtained before this claim can be paid. Provider must obtain PACER number and enter it on the claim form.	CO	Contractual Obligations	197	Precertification/authorization/notification absent. Start 10/31/06 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0710	The documentation submitted for review of this admission does not warrant a second DRG payment. The provider should include the services for this admission on the claim for the first admission. If the first admission has been paid, then these services must be included on a claim adjustment for the first admission.	CO	Contractual Obligations	150	Payer deems the information submitted does not support this level of service. Start 10/31/02 Modified 9/30/07	N149	Rebill all applicable services on a single claim. Note: (New Code 10/31/02)
0711	The Optical Character Reader could not read the typed print properly. This may be corrected by cleaning the type font, changing the ribbon, or properly aligning the claim. This explanation code is for informational purposes only.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	N205	Information provided was illegible. Note: (New Code 6/30/03)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0712	A review of this readmission appears to warrant two separate DRGs. A claim for each admission must be submitted, along with the required documentation attached to each claim.	CO	Contractual Obligations	A8	Ungroupable DRG. Start: 1/1/95 Last Modified 9/30/07	N62	Inpatient admission spans multiple rate periods. Resubmit separate claims. Start: 1/1/00
0713	This claim is a duplicate of another suspended claim and has been rejected. Do not resubmit this claim. Updated 7/27/09	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95 CARC change 7/27/09	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07) Remark Code change 7/27/09
0714	The documentation is not adequate to warrant additional payment for this service. If appropriate, a claim adjustment should be submitted with complete documentation of the service provided. This explanation code is for informational purposes only.	CO	Contractual Obligations	150	Payer deems the information submitted does not support this level of service. Start 10/31/02 Modified 9/30/07	M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code. Note: (Modified 2/1/04)
0715	Claims should be rebilled with the actual product cost of the item documented. This explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N358	Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted. Note: (New Code 11/18/05, Modified 4/1/07)
0716	This claim was rejected in error and has been resubmitted by the Department of Community Health. This explanation code is for informational purposes only.	CO	Contractual Obligations	101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start 1/1/95 Last Modified 2/28/99	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0717	The provider type code and/or provider ID Number were corrected. In the future, this information must be completed properly. This explanation code is for informational purposes only.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: (New code 12/2/04)
0718	This claim has been corrected to correspond with information on the prior authorization form. This explanation code is for informational purposes only.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0719	Reimbursement for this Medicare Part A only claim includes a full DRG payment minus the coinsurance and/or deductible payments previously paid on the Part B only claim. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06 CARC change 1/09	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0720	The diagnosis code has been corrected to correspond with the diagnosis description. This explanation code is for informational purposes only.	CO	Contractual Obligations	B22	This payment is adjusted based on the diagnosis. Start 1/1/95 Last Modified 2/28/01	N206	The supporting documentation does not match the claim. Note: (New Code 6/30/03)
0722	The date of service has been corrected to the proper format according to current billing practices. This explanation code is for informational purposes only.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	N301	Missing/incomplete/invalid procedure dates(s). Note: (New Code 12/2/04)
0723	The frequency of this service exceeds Program parameters. Medical necessity must be documented. This explanation code is for informational purposes only.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/02 Last Modified 1/27/08	N358	Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted. Note: (New Code 11/18/05, Modified 4/1/07)
0724	The information on this claim does not adequately support the use of Emergent Condition Code 1 (emergency). If appropriate, the claim should be rebilled with complete documentation supporting the Emergent Condition Code 1.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care. Start: 1/1/95	N142	The original claim was denied. Resubmit a new claim, not a replacement claim. Note: (New Code 10/31/02)
0725	This procedure, reviewed under Explanation Code 087, has been rejected. Having been previously advised of a provider's right to contest this decision, the provider may wish to address a request for an Administrative Hearing to the Manager, Administrative Tribunal and Appeals Division, PO Box 30195, Lansing, MI 48909-7695.	CO	Contractual Obligations	150	Payer deems the information submitted does not support this level of service. Start 10/31/02 Modified 9/30/07	N187	Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents. Note: (New Code 2/28/03, Modified 4/1/07)
0727	This claim has been manually rejected for reasons specified by the accompanying explanation codes with "P" (pend) indicators.	CO	Contractual Obligations	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start 1/1/95 Last Modified 10/31/06)	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0728	This rejected claim will be paid with a gross adjustment in accordance with the provisions of a letter forwarded under separate cover to the address indicated on page 1 of the Remittance Advice. The claim should not be rebilled.	CO	Contractual Obligations	121	Indemnification adjustment - compensation for outstanding member responsibility Start 1/1/95 Modified 9/30/07	M118	Alert: Letter to follow containing further information. Note: (Modified 4/1/07)
0729	This service has been billed on the wrong claim form. The provider should refer to his/her provider manual for the correct claim form to use and rebill the claim.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service. Start 1/1/95	N34	Incorrect claim form/format for this service. Note: (Modified 11/18/05)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0730	Mutually exclusive services have been billed separately and payment is not allowed. These procedures must be combined and rebilled on one claim line, using the appropriate procedure code.	CO	Contractual Obligations	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. Start: 10/31/02 Last Modified 1/27/08	N20	Service not payable with other service rendered on the same date. Start: 1/1/00
0731	Service is included in another service rendered on the same date. The service must not be rebilled.	CO	Contractual Obligations	59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 1/1/95 Last Modified: 9/30/07	N20	Service not payable with other service rendered on the same date. Start: 1/1/00
0732	This service is included in the reimbursement for the medical visit provided on the same date of service. The service must not be rebilled.	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0733	There is not sufficient information to process this claim line. The claim line should be rebilled with complete documentation to support the service provided. If claim adjusting, a copy of the Remittance Advice page showing the last payment must also be attached.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart. Note: (New Code 8/1/04, Modified 8/1/05)
0734	The quantity billed on this line is not consistent with the billing unit specified in the Michigan Pharmaceutical Product List (MPPL). The claim should be billed with the correct quantity as specified in the MPPL.	CO	Contractual Obligations	154	Payer deems the information submitted does not support this day's supply. Start: 10/31/02 Last Modified 9/30/07	M53	Missing/incomplete/invalid days or units of service. Note: (Modified 2/28/03)
0735	Multiple services are combined on one claim line. Each service should be rebilled on a separate claim line.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	N63	Rebill services on separate claim lines. Start: 1/1/00
0736	This service is included in the surgical fee/delivery fee/antepartum fee. The service must not be rebilled.	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure. Start: 1/1/97
0737	Service rendered is not a covered benefit of the program. The service must not be rebilled.	CO	Contractual Obligations	204	This service/equipment/drug is not covered under the patient's current benefit plan. Start: 2/28/07	N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008

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EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0738	This service is included as a component part of another service and cannot be reimbursed separately. The service must not be rebilled.	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: (Modified 6/30/03)
0739	According to documentation or remarks submitted with this claim it appears that the code(s) billed do/does not accurately represent the service(s) provided. All codes should be reviewed and the claim should be corrected and rebilled with the appropriate code(s) for the services provided.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service. Start 1/1/95	N163	Medical record does not support code billed per the code definition. Note: (New Code 2/28/03)
0740	In order for this claim to be reconsidered for payment it is necessary for you to resubmit the claim with a copy of the operative/pathology report or office/progress notes.	CO	Contractual Obligations	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start 1/1/95 Last Modified 10/31/06)	N29	Missing documentation/orders/notes/summary/report/chart. Note: (Modified 2/28/03, 8/1/05) Related to N225
0741	This payment reflects the maximum Medicaid allowance minus the other insurance payment indicated on the claim. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06 CARC change 1/09	N45	Payment based on authorized amount. Start: 1/1/00
0742	The surgical procedures should be rebilled according to Program guidelines, in the proper sequence (indicating the primary procedure on the first claim line), with appropriate modifiers. The claim should be corrected and rebilled.	CO	Contractual Obligations	59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 1/1/95 Last Modified 2/28/07	N149	Rebill all applicable services on a single claim. Note: (New Code 10/31/02)
0743	This claim has been manually rejected due to technical reasons. The provider should not submit a new claim. The Department of Community Health will re-enter the claim. It will be processed under a new Claim Reference Number and will appear on a future Remittance Advice.	CO	Contractual Obligations	101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start 1/1/95 Last Modified 2/28/99	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0744	The claim has been denied because the provider signature is missing. The claims should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA81	Missing/incomplete/invalid provider/supplier signature. Note: (Modified 2/28/03)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0745	The drug listed on the claim cannot be paid without additional information, including the manufacturer, National Drug Code, and dose (quantity given). The invoice from the manufacturer, wholesaler, or pharmacy must be attached to the rebilled claim.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC change 10-07	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: (Modified 2/28/03)
0746	This service cannot be series billed. Each date of service must be rebilled on separate claim lines.	CO	Contractual Obligations	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start 1/1/95 Last Modified 10/31/06)	N63	Rebill services on separate claim lines. Start: 1/1/00
0747	Only one initial consultation or comprehensive exam is allowed within a six month period.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	N113	Only one initial visit is covered per physician, group practice or provider. Note (New Code 4/16/02 Modified 6/30/03)
0748	Services performed for the reported diagnosis code are not reimbursable due to the age or gender of the beneficiary. The service must not be rebilled.	CO	Contractual Obligations	11	The diagnosis is inconsistent with the procedure. Start: 1/1/95	MA63	Missing/incomplete/invalid principal diagnosis. Note: (Modified 2/28/03)
0749	The pharmacy should recheck that the correct metric-billing unit, as listed in the Michigan Pharmaceutical Product List (MPPL), was used for the Quantity entry. Drug quantity exceeding the Department of Community Health's established allowable amounts must be fully documented by "daily dosage instructions." The claim should be rebilled with the appropriate documentation or corrected metric billing units.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC change 10-07	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: (Modified 2/28/03)
0750	Reimbursement cannot be determined for this product without additional information, such as product name, manufacturer, National Drug Code or product number, dosage, form, strength, and quantity dispensed. The claim should be rebilled with complete documentation.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06 CARC change 10-07	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: (Modified 2/28/03)
0751	Medicaid records do not verify that the beneficiary-pay amount has been collected for this month of service. The service must first be applied to the beneficiary's patient-pay amount. Any services that are not covered by this amount may be rebilled.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N58	Missing/incomplete/invalid patient liability amount. Note: (Modified 2/28/03)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0752	Medicaid records show this beneficiary was deceased during this period. The claim should be rebilled for services rendered prior to date the beneficiary expired.	CO	Contractual Obligations	13	The date of death precedes the date of service. Start: 1/1/95	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed. Note: (Modified 2/28/03)
0753	Emergency condition not sufficiently documented. Provider should supply more documentation and resubmit.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care. Start: 1/1/95	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart. Note: (New Code 8/1/04, Modified 8/1/05)
0754	The only noncovered services rejected by Medicare that can be billed to Medicaid are those specifically identified as Medicare exclusions. The provider should contact Medicare to determine the reason for the Medicare rejection. If the claim was rejected by Medicare because: Ø The service was billed incorrectly to Medicare, the provider should rebill Medicare. Ø The service was not medically necessary, Medicaid will not reimburse for the service. Ø The service is not a Medicare covered service, the provider may rebill Medicaid. The service must be rebilled on a separate claim. Only Medicare excluded services should be included on the claim.	CO	Contractual Obligations	136	Failure to follow prior payer's coverage rules. Start: 10/31/98 Last Modified 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0755	Those services covered by Medicare cannot be combined on one claim with services not covered by Medicare. The provider must bill covered Medicare services on one claim and Medicare noncovered services on a second claim with the appropriate Medicare status code on each claim.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06 CARC change 1/09	N59	Alert: Please refer to your provider manual for additional program and provider information. Note: (Modified 4/1/07)
0756	The payment information on the claim is inconsistent with the Medicare EOB. The claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code) Start 1/1/95 Last Modified 4/1/07 CARC change 10-07	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97
0757	An invoice cannot be submitted to adjust a previous payment. For proper claim adjustment/replacement procedures please see the appropriate provider specific billing and reimbursement chapter of the Medicaid Manual.	CO	Contractual Obligations	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment. Start: 1/1/95	N152	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0758	This claim adjustment or replacement cannot be processed because some or all of the information does not match the original claim. Please review the paid claim and verify the provider ID #, beneficiary ID# and original claim reference number. NOTE: A rejected claim cannot be claim adjusted, but requires submission of a new claim. Also, for purposes of claim adjusting, a claim that indicated a \$0.00 payment is considered a paid claim.	CR	Correction and Reversals	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment. Start: 1/1/95	N152	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97
0759	Series billing on any one claim line cannot encompass services rendered in more than one calendar month. The last date in the month that the service was rendered must be used. The claim should be rebilled indicating one calendar month per claim line. Note: For long-term care-facilities: When billing for more than one month of service, each month must be submitted on separate claims.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month. Start: 1/1/00
0760	This service requires prior authorization. Since prior authorization was not obtained, the service is not covered by Medicaid. The beneficiary, his/her family, or representative must not be billed for this service.	CO	Contractual Obligations	197	Precertification/authorization/notification absent. Start 10/31/06 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0761	The necessary documentation was not received. The claim should be rebilled with appropriate, complete, legible documentation.	CO	Contractual Obligations	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 09/21/2008	N358	Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted. Note: (New Code 11/18/05, Modified 4/1/07)
0762	The submitted documentation was not adequate or not legible. The claim should be rebilled with complete, legible documentation.	CO	Contractual Obligations	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 09/21/2008	N225	Incomplete/invalid documentation/orders/notes/summary/report/chart. Note: (New Code 8/1/04, Modified 8/1/05)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0763	The date of service is more than 12 months old and the Department of Community Health is unable to verify previous activity. If the required documentation is available, the claim should be rebilled indicating the appropriate Pay Cycle numbers and Claim Reference Numbers of previous claim submissions for this service. Information on the billing limitation is available in the General Information for Providers Chapter of the Medicaid Manual.	CO	Contractual Obligations	29	The time limit for filing has expired. Start: 1/1/95	MA69	Missing/incomplete/invalid remarks Note: (Modified 2/28/03)
0764	The date of service is more than 12 months old and the Department of Community Health is unable to verify previous activity. The documentation of prior activity is incomplete or differs from the original claim. If appropriate, the claim should be resubmitted with an explanation of the difference or with additional/corrected information.	CO	Contractual Obligations	29	The time limit for filing has expired. Start: 1/1/95	N225	Incomplete/invalid documentation/ orders/notes/summary/report/chart. Note: (New Code 8/1/04, Modified 8/1/05)
0765	The date of service is more than 12 months old. The Department of Community Health is unable to verify previous activity and the documentation of prior activity was not complete. If the required documentation is available, the claim should be rebilled indicating the appropriate Pay Cycle numbers and Claim Reference Numbers of previous claim submissions for this service. Information on the billing limitation is available in the General Information for Providers Chapter of the Medicaid Manual.	CO	Contractual Obligations	29	The time limit for filing has expired. Start: 1/1/95	N225	Incomplete/invalid documentation/orders/notes/summary/repor t/chart. Note: (New Code 8/1/04, Modified 8/1/05)
0766	A claim adjustment to request additional monies for a service can be billed up to 12 months from the date of the original payment. Information on the billing limitation in regards to claim replacements is available in the General Information for Providers Chapter of the Medicaid Manual.	CO	Contractual Obligations	29	The time limit for filing has expired. Start: 1/1/95	N152	Missing/incomplete/invalid replacement claim information. Note: (New Code 10/31/02)
0767	The date of service is more than 12 months from the date the claim was received by DCH. It appears that Medicare may have prevented the claim from being billed to Medicaid. Information regarding the billing limitation is available in the General Information for Providers Chapter of the Medicaid Manual.	CO	Contractual Obligations	29	The time limit for filing has expired. Start: 1/1/95	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0769	Drug code for the service billed is listed in the drug code listing.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Note: (Modified 2/28/03)
0771	The review of Medicaid records shows that this claim was previously paid. The claim must not be rebilled.	CO	Contractual Obligations	18	Duplicate claim/service. Start 1/1/95	M86	Service denied because payment already made for same/similar procedure within set time frame. Note: (Modified 6/30/03)
0772	Program records indicate that this beneficiary has, or is eligible for, Medicare. *If the beneficiary is eligible for, but not enrolled in, Medicare the provider should encourage the beneficiary to contact the local Social Security Administration office to apply/reapply. For Inpatient Hospital Charges Only: The beneficiary is currently enrolled in Medicare Part B only. The provider should refer to the Coordination of Benefits Chapter of the Medicaid Manual for instructions to initiate Medicare Part A coverage.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0773	Medicaid reimbursement cannot be made for this service without further documentation from Medicare The provider should rebill the claim and include the appropriate documentation. (e.g., Explanation of Benefits, voucher, written explanation). LONG-TERM CARE PROVIDERS: The Explanation of Benefits is not acceptable documentation. HOME HEALTH AGENCIES: Do not rebill to Medicaid, no reimbursement will be made, Medicare covers 100% of the cost or charge for Home Health services.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N29	Missing documentation/orders/notes/summary/report/chart. Note: (Modified 2/28/03, 8/1/05) Related to N225
0774	We have not received either an Informed Consent to Sterilization (MSA-1959) or Acknowledgment of Receipt of Hysterectomy Information (MSA-2218) form. Submit a completed form.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N3	Missing consent form. Note: (Modified 2/28/03) Related to N228

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0775	The Informed Consent to Sterilization or Acknowledgment of Receipt of Hysterectomy Information form is invalid due to one or more of the following: Ø required information is missing, Ø information on the form does not match the claim, Ø the form is not appropriate for the procedure, or Ø the form is not accepted by the Program as a valid form (e.g., MSA-1959 or MSA-2218). This service cannot be billed to the beneficiary, his/her family or representative.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N228	Incomplete/invalid consent form. Note: (New Code 8/1/04)
0776	The diagnosis code indicated does not match the diagnosis file. The provider should verify the diagnosis code used, correct, and rebill the claim.	CO	Contractual Obligations	167	This (these) diagnosis (es) is (are) not covered. Start: 6/30/05	M76	Missing/incomplete/invalid diagnosis or condition. Note: (Modified 2/28/03)
0777	Claim information is inconsistent with the submitted documentation or it is inconsistent with authorized services. All data should be verified.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N206	The supporting documentation does not match the claim. Note: (New Code 6/30/03)
0778	Medical necessity for the services billed is not reflected by the diagnosis code. All data should be verified, including the diagnosis code subclassification digits, where indicated. If appropriate, corrections should be made and the claim rebilled. If the data is correct, the service must not be rebilled.	CO	Contractual Obligations	50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Start 1/1/95	M76	Missing/incomplete/invalid diagnosis or condition. Note: (Modified 2/28/03)
0779	Unnecessary hospital days, or services contrary to Program requirements, are not reimbursable. This claim must not be rebilled until the provider has received the rebilling instructions.	CO	Contractual Obligations	152	Payer deems the information submitted does not support this length of service. Start: 10/31/02 Last Modified 9/30/07	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0780	This beneficiary ID Number does not match the name and birthdate on the claim. The provider should verify the beneficiary ID Number with either the Medicaid ID Card/Eligibility Notice or the Eligibility Verification System. The claim should be corrected and rebilled.	CO	Contractual Obligations	140	Patient/Insured health identification number and name do not match. Start: 6/30/99	N382	Missing/incomplete/invalid patient identifier. Start: 4/1/07
0781	The claim appears to have been billed using the mother's beneficiary ID Number and the services are for a child. The provider should rebill the claim using the child's ID Number.	CO	Contractual Obligations	140	Patient/Insured health identification number and name do not match. Start: 6/30/99	N15	Services for a newborn must be billed separately. Start 1/1/00

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0782	This beneficiary does not have Medicare Part A, or Part A benefits are exhausted. The hospital charges for laboratory and/or radiology services must be included on a separate claim with other Part B charges. The provider should bill one claim showing all Part A charges, and a second claim showing all Part B charges, including the hospital laboratory and/or radiology charges.	CO	Contractual Obligations	119	Benefit maximum for this time period or occurrence has been reached. Start: 1/1/95 Last Modified: 2/29/04	M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available. Start: 1/1/97
0783	The Department of Community Health's records indicate that the beneficiary's beneficiary-pay amount exceeds the total amount billed on this claim. The service must not be rebilled.	CO	Contractual Obligations	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0784	Multiple procedures or services have been billed on separate claims. A claim replacement must be submitted in order to be reimbursed for this service. Instructions on submitting a claim replacement can be found in the provider specific billing and reimbursement chapter(s) of the Medicaid Manual.	CO	Contractual Obligations	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment. Start: 1/1/95	N149	Rebill all applicable services on a single claim. Note: (New Code 10/31/02)
0785	Services billed exceed program limitations. The service must not be rebilled.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	N185	Alert: Do not resubmit this claim/service. Note: (New Code 2/28/03, Modified 4/1/07)
0786	Services billed on this claim do not match services on the prior authorization on file.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0787	Beneficiary ID # on the claim does not match the beneficiary ID on the PA or submitted documentation. All data should be verified. If appropriate, corrections should be made and the claim rebilled. If the data is correct, the service must not be rebilled.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N206	The supporting documentation does not match the claim. Note: (New Code 6/30/03)
0789	The other insurance code indicates payment made, yet there is no other insurance payment shown on the claim. The claim should be corrected and rebilled.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97
0790	The required documentation regarding other insurance action is not complete. Information regarding other insurance can be found in the Coordination of Benefits Chapter of the Medicaid Manual. The claim should be corrected and rebilled.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N59	Alert: Please refer to your provider manual for additional program and provider information. Note: (Modified 4/1/07)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0792	The beneficiary is not eligible and there is no pending application on file. The service must not be rebilled.	CO	Contractual Obligations	31	Patient cannot be identified as our insured. Start: 1/1/95 Last Modified 9/30/07	N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008
0793	The other insurance policy has master medical coverage. The service must be billed to the other insurance carrier.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0795	A manual review indicates these services are covered and benefits are currently available from another insurance carrier.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0796	This compounded prescription cannot be processed as the ingredients are not sufficiently identified by name, manufacturer, National Drug Code, strength, form, and quantity. The claim should be rebilled indicating complete documentation of the ingredients of the compound.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished. Note: (Modified 2/28/03)
0797	There is an invalid relationship between the procedure code, diagnosis code, or drug code and the description of the services rendered. All data should be verified. If appropriate, corrections should be made and the claim rebilled. If the data is correct, the service must not be rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Note: (Modified 2/28/03)
0798	These services cannot be billed under the mother's ID Number. These services must be rebilled under the child's ID Number.	CO	Contractual Obligations	140	Patient/Insured health identification number and name do not match.	N15	Services for a newborn must be billed separately. Start 1/1/00
0799	(Adult Benefits Waiver Program only) This claim was not prior authorized and the diagnosis does not support emergency coverage.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care. Start: 1/1/95	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service. Start: 10/31/2002 Last Modified: 7/1/2008 Note: (Modified 4/1/07, 7/1/08)
0800	The payment is for the quantity shown. This explanation code is for informational purposes only.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0802	Other insurance or Medicare money manually distributed. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N219	Payment based on previous payer's allowed amount. Note: (New Code 8/1/04)
0803	This provider type is not allowed for the beneficiary's age. The claim must not be rebilled.	CO	Contractual Obligations	6	The procedure code is inconsistent with the patient's age. Start 1/1/95 Last Modified 6/30/02	N95	This provider type/provider specialty may not bill this service. Note: (New code 7/31/01, Modified 2/28/03)
0804	Services rendered to this county's Adult Benefits Waiver beneficiaries are the responsibility of the county. Providers should contact the Department of Human Services office for information regarding where to submit bills for these services.	CO	Contractual Obligations	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. Start: 1/1/95	N182	This claim/service must be billed according to the schedule for this plan. Note: (New Code 2/28/03)
0805	Adult Benefits Waiver Program (ABW). Effective 11-01-1999 and after, payments for Adult Benefits Waiver (formerly State Medical Program) services will be made by the Detroit Medical Center (DMC). Providers should continue to submit claims for services to Adult Benefits Waiver Program beneficiaries to the Department of Community Health (DCH). DCH will continue to process the claims but payment will be issued by DMC. The explanation code is for informational purposes only.	CO	Contractual Obligations	24	Charges are covered under a capitation agreement/managed care plan. Start 1/1/95 Last Modified 9/30/07	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service. Start: 10/31/2002 Last Modified: 7/1/2008 Note: (Modified 4/1/07, 7/1/08)
0806	The procedure code is inconsistent with the modifier used or a required modifier is missing.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	M51	Missing/incomplete/invalid procedure code (s) Note: (Modified 12/2/04) Related to N301
0809	The service billed is part of the Mental Health or Substance Abuse Capitation and cannot be billed directly to DCH. These services should be billed to the Mental Health or Substance Abuse contractor in the beneficiary's catchment area.	CO	Contractual Obligations	24	Charges are covered under a capitation agreement/managed care plan. Start 1/1/95 Last Modified 9/30/07	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service. Start: 10/31/2002 Last Modified: 7/1/2008 Note: (Modified 4/1/07, 7/1/08)
0814	This National Drug Code (NDC) is being manually priced.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0817	Outpatient hospital: Payment on this line is determined by group reimbursement policy. See section 7 of the Institutional Billing And Reimbursement chapter, procedure code/revenue code list. This explanation code is for informational purposes only. Revision 6-06	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	N59	Alert: Please refer to your provider manual for additional program and provider information. Note: (Modified 4/1/07)
0819	Did not complete or enter accurately an appropriate HCPCS modifier.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	M20	Missing/incomplete/invalid HCPCS. Note: (Modified 2/28/03)
0827	Claim/service lacks a valid COB code which is needed for adjudication.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97
0828	Our records indicate that there is insurance primary to ours; however, you either did not complete or enter accurately the group or policy number of the insured. This explanation code is for informational purposes only.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N245	Incomplete/invalid plan information for other insurance. Note: (New code 8/1/04)
0829	Secondary payment cannot be considered without the identity of, or payment information from, the primary payer. The information was either not reported or was illegible.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97
0838	A modifier identified on the claim is pending further review.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0839	The reported modifier is invalid for either the procedure code billed or the provider type.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed. Note: (Modified 2/28/03)
0840	The claim is reimbursed using the DRG policies. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0841	Claim Cannot be Grouped under DRGs/APCs	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N180	This item or service does not meet the criteria for the category under which it was billed. Note: (New Code 2/28/03)
0843	The services on this claim, for this DRG, are reimbursed on a percent-of-charge basis. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0844	The claim indicates a low-cost outlier.	CO	Contractual Obligations	69	Day outlier amount. Start: 1/1/95	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0845	The alternative weight for the DRG reimbursement for this hospital was used in determining the reimbursement amount. This explanation code is for informational purposes only.	CO	Contractual Obligations	B22	This payment is adjusted based on the diagnosis. Start: 1/1/95 Last Modified: 2/28/01	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0846	The inpatient hospital claim is for a transfer beneficiary and is paid the daily DRG rate. This explanation code is for informational purposes only.	CO	Contractual Obligations	87	Transfer amount. Start: 1/1/95	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0847	The claim indicates a low-day outlier. The claim is reimbursed at a percent-of-charge basis not to exceed the full DRG payment. This explanation code is for informational purposes only.	CO	Contractual Obligations	69	Day outlier amount. Start: 1/1/95	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0848	The claim indicates a high-day outlier. This explanation code is for informational purposes only.	CO	Contractual Obligations	70	Cost outlier - Adjustment to compensate for additional costs. Start: 1/1/95 Last Modified: 6/30/01	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0849	The claim indicates a high-cost outlier. This explanation code is for informational purposes only.	CO	Contractual Obligations	70	Cost outlier - Adjustment to compensate for additional costs. Start: 1/1/95 Last Modified: 6/30/01	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0850	The beneficiary was readmitted within 15 days of a previous discharge. Only the outlier payment is approved. This explanation code is for informational purposes only.	CO	Contractual Obligations	69	Day outlier amount. Start: 1/1/95	N47	Claim conflicts with another inpatient stay. Start: 1/1/00
0854	The Medicare coinsurance and deductible amounts for this DRG are being reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	MA63	Missing/incomplete/invalid principal diagnosis. Note: (Modified 2/28/03)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0855	The DRG assignment is being manually reviewed.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0857	This DRG is being manually reviewed to determine the medical necessity and/or appropriateness of the admission.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0858	Individual consideration has been requested for reasons other than transfer or readmission.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N45	Payment based on authorized amount. Start: 1/1/00
0860	The claim does not contain sufficient information for a reimbursement determination.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. Start 10/12/01
0863	The beneficiary was transferred to another facility/unit and the hospital has requested individual consideration for the full DRG payment.	CO	Contractual Obligations	133	The disposition of this claim/service is pending further review. Start: 2/28/97 Last Modified: 10/31/99	N45	Payment based on authorized amount. Start: 1/1/00
0864	Did not complete or enter accurately the CLIA number.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	MA120	Missing/incomplete/invalid CLIA certification number. Note: (Modified 2/28/03)
0865	The combination of modifiers is invalid.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	M20	Missing/incomplete/invalid HCPCS Note: (Modified 2/28/03)
0866	Physician ER case rate: This claim line is for a service provided in the ER that is included in the ER case rate payment. This service has been paid zero dollars. This explanation code is for informational purposes only.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	M85	Subjected to review of physician evaluation and management services. Start: 1/1/97

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0868	The beneficiary was admitted and discharged on the same day and an accommodation day was billed. This explanation code is for informational purposes only.	CO	Contractual Obligations	150	Payer deems the information submitted does not support this level of service. Start 10/31/02 Modified 9/30/07	M53	Missing/incomplete/invalid days or units of service. Note: (Modified 2/28/03)
0874	There is a problem with the HMO ID & the beneficiary's eligibility type.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	N52	Patient not enrolled in the billing provider's managed care plan on the date of service. Start: 1/1/00
0875	Procedure code is not compatible with tooth number/letter. If appropriate, the claim should be corrected and rebilled.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N75	Missing/incomplete/invalid tooth surface information. Note: (Modified 2/28/03)
0876	A Medicare rate cell was used to pay the Medicaid Health Plan capitation rate for the beneficiary. The explanation code is for informational purposes only.	CO	Contractual Obligations	24	Charges are covered under a capitation agreement/managed care plan. Start 1/1/95 Last Modified 9/30/07	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0877	Pharmacy claims after July 2000 should be billed to First Health Services.	CO	Contractual Obligations	166	These services were submitted after this payers responsibility for processing claims under this plan ended. Start: 2/28/05	N193	Specific federal/state/local program may cover this service through another payer. Note: (New Code 2/8/03)
0878	The modifier billed indicating surgical assist, surgical team or co-surgeon is not allowed for this procedure or is not documented.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	M20	Missing/incomplete/invalid HCPCS Note: (Modified 2/28/03)
0879	The modifier billed indicating surgical assist, surgical team or co-surgeon is being reviewed.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start 1/1/95	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor. Start: 1/1/2000 Last Modified: 7/1/2008 Note: (Modified 10/31/02, 7/1/08)
0880	The total amount billed on this claim is \$0.00. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N131	Total payments under multiple contracts cannot exceed the allowance for this service. Note: (New Code 10/31/02)
0881	This beneficiary has Medicare coverage and the claim indicates the beneficiary is not eligible for Medicare. The provider should verify that the correct COB indicator/status code was used, and rebill the claim.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N48	Claim information does not agree with information received from other insurance carrier. Start: 1/1/00

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0882	This beneficiary has Medicare coverage and the claim indicates the beneficiary is not eligible for Medicare. The provider should verify that the correct COB indicator/status code was used, and rebill the claim.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N48	Claim information does not agree with information received from other insurance carrier. Start: 1/1/00
0883	The beneficiary is enrolled in a Medicaid Health Plan on the date of service but the hospital admission might be before the enrollment date.	CO	Contractual Obligations	24	Charges are covered under a capitation agreement/managed care plan. Start 1/1/95 Last Modified 9/30/07	N193	Specific federal/state/local program may cover this service through another payer. Note: (New Code 2/8/03)
0884	Modifier 54, 55 or 56 billed with a procedure code that does not allow this/these modifier(s).	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	M20	Missing/incomplete/invalid HCPCS Note: (Modified 2/28/03)
0886	For dates of service February 01, 2000 thru September 30, 2000, Health Plans are reimbursed directly by Medicaid only for psychotropic drugs dispensed to enrolled beneficiaries enrolled in the Health Plan. For dates of service October 01, 2000 and after, First Health Services is responsible for the Medicaid Health Plan psychotropic drug claims.	CO	Contractual Obligations	166	These services were submitted after this payers responsibility for processing claims under this plan ended. Start: 2/28/05	N193	Specific federal/state/local program may cover this service through another payer. Note: (New Code 2/8/03)
0888	The Department's payment to Health Plans for psychotropic drugs (other than anti-psychotic and side-effect drugs) is 60% of the lower of: The total Medicaid fee-for-service rate for product cost & dispensing fee, OR The Health Plan's contract pharmacy rate billed to the Department. NOTE: Anti-Psychotic and Side-Effect Drugs are paid at 100%, not 60%. The explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0889	The occurrence code is missing. This explanation code is for informational purposes only.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	M45	Missing/incomplete/invalid occurrence code(s). Note: (Modified 12/2/04) Related to N299
0890	A modifier not appropriate for the procedure code has been reported and was not used to determine reimbursement. This explanation code is for informational purposes only.	CO	Contractual Obligations	4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Start: 1/1/95	M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code. Note (Modified 2/1/04)
0891	This claim is reimbursed at the operating per diem plus capital costs per case. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0892	The wrong invoice document or electronic format was used.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	N34	Incorrect claim form/format for this service. Note: (Modified 11/18/05)
0893	Maternity case rate was paid. This explanation code is for informational purposes only.	CO	Contractual Obligations	24	Charges are covered under a capitation agreement/managed care plan. Start 1/1/95 Last Modified 9/30/07	N45	Payment based on authorized amount. Start: 1/1/00
0894	Beneficiary not eligible for maternity case rate carve out.	CO	Contractual Obligations	177	Patient has not met the required eligibility requirements. Start: 6/30/05 Last Modified 9/30/07	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0895	This claim is reimbursed under the standard rate DRG methodology. The explanation code is for informational purposes only.	CO	Contractual Obligations	B22	This payment is adjusted based on the diagnosis. Start: 1/1/95 Last Modified: 2/28/01	N45	Payment based on authorized amount. Start: 1/1/00
0896	This claim is an additional page of a multi-page claim. No reimbursement is to be made. The explanation code is for informational purposes only.	CO	Contractual Obligations	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Start: 1/1/95 Last Modified: 9/30/07	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed. Start 1/1/97
0915	Services in the inpatient hospital setting are not benefits of the Adult Benefits Waiver Program. The claim must not be rebilled.	CO	Contractual Obligations	204	This service/equipment/drug is not covered under the patient's current benefit plan. Start: 2/28/07	N30	Patient ineligible for this service. Note: (Modified 6/30/03)
0929	The patient-pay amount has been subtracted from the amount approved. This explanation code is for informational purposes only.	PR	Patient Responsibility. Change 4/06.	142	Monthly Medicaid patient liability amount. Start: 6/30/00 Last Modified 9/30/07	N246	State regulated patient payment limitation apply to this service. Note: (New Code 12/2/04)
0931	This beneficiary is eligible for the Resident County Hospitalization program as authorized by Wayne County. The hospital did not use the provider ID Number for the Wayne County PLUS CARE Program. The hospital must rebill using the correct provider ID Number.	CO	Contractual Obligations	24	Charges are covered under a capitation agreement/managed care plan. Start 1/1/95 Last Modified 9/30/07	N257	Missing/incomplete/invalid billing provider/supplier primary identifier. Note: (New code 12/2/04)
0932	The inpatient hospital claim indicates Source of Admission Form Locator 4 (Transfer from another hospital), or 6 (Transfer from another health care facility), and no admission authorization number is indicated on the claim. This explanation code is for informational purposes only.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0933	The physician's claim requires an authorization number for the admission. This explanation code is for informational purposes only.	CO	Contractual Obligations	101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start 1/1/95 Last Modified 2/28/99	N45	Payment based on authorized amount. Start: 1/1/00

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0934	The date of admission is prior to the date of the admission authorization number.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0935	The admission date is more than 30 days after the date of the admission authorization number.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0936	The admission/readmission/transfer authorization number is missing.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0937	The admission/readmission/transfer authorization number is invalid.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	M62	Missing/incomplete/invalid treatment authorization code. Note: (Modified 2/28/03)
0938	The admission/readmission/transfer authorization number on the claim was not assigned to this beneficiary.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0940	The admission date on the claim does not match the from date.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	MA40	Missing/incomplete/invalid admission date. Note: (Modified 2/28/03)
0941	The hospice value code for the MSA number is missing or invalid. The claim should be rebilled with the appropriate MSA number.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M49	Missing/incomplete/invalid value code(s) or amount(s). Note: (Modified 2/28/03)
0942	The secondary surgical procedure requires an admission authorization number. This explanation code is for informational purposes only.	CO	Contractual Obligations	101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start 1/1/95 Last Modified 2/28/99	N45	Payment based on authorized amount. Start: 1/1/00
0944	The primary surgical procedure requires an admission authorization number. This explanation code is for informational purposes only.	CO	Contractual Obligations	101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start 1/1/95 Last Modified 2/28/99	N45	Payment based on authorized amount. Start: 1/1/00
0946	The elective admission requires an admission authorization number. This explanation code is for informational purposes only.	CO	Contractual Obligations	101	Predetermination: anticipated payment upon completion of services or claim adjudication. Start 1/1/95 Last Modified 2/28/99	N45	Payment based on authorized amount. Start: 1/1/00
0947	A Patient Status Code of 30 (still a patient) was used on the inpatient hospital claim.	CO	Contractual Obligations	B5	Coverage/program guidelines were not met or were exceeded. Start 1/1/95 Last Modified 9/30/07	N173	No qualifying hospital stay dates were provided for this episode of care. Note: (New Code 2/28/03)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0949	Professional charges are not allowed on an inpatient claim. Providers should refer to the billing chapter of the appropriate provider manual for instructions for billing professional services. The inpatient charges should be rebilled on the inpatient hospital invoice.	CO	Contractual Obligations	170	Payment is denied when performed/billed by this type of provider. Start 6/30/05	N61	Rebill services on separate claims. Start: 1/1/00
0952	Billing for more coinsurance days than claim line quantities.	CO	Contractual Obligations	152	Payer deems the information submitted does not support this length of service. Start: 10/31/02 Last Modified 9/30/07	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period. Note: (Modified 2/28/03)
0953	The office co-payment has been deducted for the Adult Benefits Waiver Program beneficiaries. This explanation code is for informational purposes only.	CO	Contractual Obligations	3	Co-payment Amount Start : 1/1/95	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0954	The adjustment reason code from the prior payer is being reviewed.	CO	Contractual Obligations	22	This care may be covered by another payer per coordination of benefits. Start: 1/1/95 Last Modified: 9/30/07	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0955	The National Drug Code is missing or invalid.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	M119	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC). Note: (Modified 2/28/03, 4/1/04)
0958	Medicaid cannot pay your claim based on the Claim Adjustment Reason Codes supplied by the prior payer.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N36	Claim must meet primary payer's processing requirements before we can consider payment. Start: 1/1/00
0959	The extended stay authorization number for a psychiatric or rehabilitation admission does not match the period being billed.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0960	The authorization number does not match this psychiatric stay.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0966	Emergency ambulance invoice without emergency diagnosis code. The provider should enter the correct emergency diagnosis code from the ICD-9-CM code book in the diagnosis field of the claim form.	CO	Contractual Obligations	40	Charges do not meet qualifications for emergent/urgent care. Start: 1/1/95	M76	Missing/incomplete/invalid diagnosis or condition. Note: (Modified 2/28/03)

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0967	Non-emergency ambulance code without referring provider ID Number. The provider should enter the ordering physician's name and Medicaid ID Number on the claim form and rebill.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N286	Missing/incomplete/invalid referring provider primary identifier. Note: (New Code 12/2/04)
0969	Minimum quantity of 8 was not billed for continuous home care. The provider should confirm the services being billed.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M53	Missing/incomplete/invalid days or units of service. Note: (Modified 2/28/03)
0970	Hospice services were billed for a beneficiary whose Level of Care is not 16. The Level of Care code should be verified and the claim rebilled as appropriate.	CO	Contractual Obligations	150	Payer deems the information submitted does not support this level of service. Start 10/31/02 Modified 9/30/07	N143	The patient was not in a hospice program during all or part of the service dates billed. Note: (New Code 10/31/02)
0971	The supporting HCPCS code is invalid or missing. The claim should be rebilled with the appropriate HCPCS code.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M20	Missing/incomplete/invalid HCPCS. Note: (Modified 2/28/03)
0972	Medicare pays 100% of this service. The service must not be rebilled.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement. Start: 1/1/00
0973	The provider has billed amounts (e.g., professional charges, Medicare charges, coinsurance/deductible) that are inconsistent for a Medicare coinsurance claim. The claim should be corrected and rebilled. This explanation code is for informational purposes only.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0975	Total payments may exceed Medicare co-insurance and deductible due.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. Start 1/1/97
0979	Home Health services billed for a nursing home patient.	CO	Contractual Obligations	5	The procedure code/bill type is inconsistent with the place of service. Start 1/1/95	M21	Missing/incomplete/invalid place of residence for this service/item provided in a home. Note: (Modified 2/28/03)

MDCH Explanation Code Crosswalk

EXPL CODE	EXPLANATION	Group Code		Claim Adjustment Reason Code		Remark Code	
0983	This procedure/service cannot be billed in combination with any other procedure/service billed on this date of service. The procedure/service must not be rebilled.	CO	Contractual Obligations	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated Start: 1/1/95 Last Modified: 9/30/07	N20	Service not payable with other service rendered on the same date. Start: 1/1/00
0984	The procedure code requires documentation and documentation was not received with the claim. The claim should be rebilled with appropriate documentation attached.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N29	Missing documentation/orders/notes/summary/report/chart. Note: (Modified 2/28/03, 8/1/05) Related to N225
0987	The Claim Adjustment Reason Codes supplied by the prior payer have been used to calculate the amount payable by Medicaid.	CO	Contractual Obligations	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Start 1/1/95 Last Modified 10/31/06	MA125	Per legislation governing this program, payment constitutes payment in full. Start 1/1/97
0989	The date of service is not within the month for which services were authorized.	CO	Contractual Obligations	15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 1/1/95 Last Modified 9/30/07	N54	Claim information is inconsistent with pre-certified/authorized services. Start: 1/1/00
0990	This claim requires documentation and documentation was not in the Remarks section of the claim or attached to the claim.	CO	Contractual Obligations	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Code or NCPDP Reject Reason Code.) Start 01/01/1995 Last Modified 6/30/06	N29	Missing documentation/orders/notes/summary/report/chart. Note: (Modified 2/28/03, 8/1/05) Related to N225
0991	The procedure code/bill type is inconsistent with the place of service or incomplete/invalid place of service. This explanation is for informational purposes only.	CO	Contractual Obligations	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	M77	Missing/incomplete/invalid place of service. Note: (Modified 2/28/03)
0992	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this facility, or by a provider of this specialty. This explanation code is for informational purposes only.	CO	Contractual Obligations	8	Start 1/1/95 Last Modified 9/30/07	N13	Payment based on professional/technical component modifier(s). Start: 1/1/00
0994	There is a Medicare payment but claim does not show coinsurance and deductible. Provider will need to rebill with appropriate Value code(s) and amount.	CO	Contractual Obligations	125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 1/1/95 Last Modified 9/30/07	M54	Missing/incomplete/invalid total charges. Note: (Modified 2/28/03)