

Type	Reason Code	Remark Code
Professional	18 - Duplicate claim/service.	N30 - Recipient ineligible for this service.
Professional	8 - The procedure code is inconsistent with the provider type/specialty (taxonomy).	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
Professional	24 - Charges are covered under a capitation agreement/managed care plan.	N130 - Consult plan benefit documents for information about restrictions for this service.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N198 - Rendering provider must be affiliated with the pay-to provider.
Professional	31 - Patient cannot be identified as our insured.	N365 - This procedure code is not payable. It is for reporting/information purposes only.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N198 - Rendering provider must be affiliated with the pay-to provider.
Professional	31 - Patient cannot be identified as our insured.	N365 - This procedure code is not payable. It is for reporting/information purposes only.
Professional	31 - Patient cannot be identified as our insured.	N130 - Consult plan benefit documents for information about restrictions for this service.
Professional	8 - The procedure code is inconsistent with the provider type/specialty (taxonomy).	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
Professional	133 - The disposition of this claim/service is pending further review.	N198 - Rendering provider must be affiliated with the pay-to provider.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95 - This provider type/provider specialty may not bill this service.
Professional	18 - Duplicate claim/service.	N30 - Recipient ineligible for this service.
Professional	B5 - Coverage/program guidelines were not met or were exceeded.	N130 - Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
Professional	B5 - Coverage/program guidelines were not met or were exceeded.	N130 - Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95 - This provider type/provider specialty may not bill this service.
Professional	31 - Patient cannot be identified as our insured.	N95 - This provider type/provider specialty may not bill this service.

Professional	22 - This care may be covered by another payer per coordination of benefits.	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.
Professional	133 - The disposition of this claim/service is pending further review.	N198 - Rendering provider must be affiliated with the pay-to provider.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95 - This provider type/provider specialty may not bill this service.
Professional	#N/A	N129 - Not eligible due to the patient's age.
Professional	6 - The procedure/revenue code is inconsistent with the patient's age.	N129 - This amount represents the dollar amount not eligible due to the patient's age.
Professional	133 - The disposition of this claim/service is pending further review.	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
Professional	31 - Patient cannot be identified as our insured.	M76 - Missing/incomplete/invalid diagnosis or condition.
Professional	45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N48 - Claim information does not agree with information received from other insurance carrier.
Professional	204 - This service/equipment/drug is not covered under the patient's current benefit plan	N30 - Recipient ineligible for this service.
Professional	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.)	MA120 - Missing/incomplete/invalid CLIA certification number.
Professional	24 - Charges are covered under a capitation agreement/managed care plan.	N130 - Consult plan benefit documents for information about restrictions for this service.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95 - This provider type/provider specialty may not bill this service.
Professional	31 - Patient cannot be identified as our insured.	M77 - Missing/incomplete/invalid place of service.
Professional	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.)	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.

Professional	B5 - Coverage/program guidelines were not met or were exceeded.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	B5 - Coverage/program guidelines were not met or were exceeded.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	18 - Duplicate claim/service.	M86 - Service denied because payment already made for similar procedure within set time frame.
Professional	31 - Patient cannot be identified as our insured.	M77 - Missing/incomplete/invalid place of service.
Professional	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.)	MA120 - Missing/incomplete/invalid CLIA certification number.
Professional	31 - Patient cannot be identified as our insured.	N130 - Consult plan benefit documents for information about restrictions for this service.
Professional	31 - Patient cannot be identified as our insured.	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
Professional	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.)	M47 - Missing/incomplete/invalid internal or document control number.
Professional	133 - The disposition of this claim/service is pending further review.	M47 - Missing/incomplete/invalid internal or document control number.
Professional	31 - Patient cannot be identified as our insured.	N95 - This provider type/provider specialty may not bill this service.
Professional	11 - The diagnosis is inconsistent with the procedure.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.

Professional	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 - Missing/incomplete/invalid treatment authorization code.
Professional	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	N54 - Claim information is inconsistent with pre-certified/authorized services.
Professional	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	N54 - Claim information is inconsistent with pre-certified/authorized services.
Professional	B22 - This payment is adjusted based on the diagnosis.	M76 - Missing/incomplete/invalid diagnosis or condition.
Professional	29 - The time limit for filing has expired.	N59 - Please refer to your provider manual for additional program and provider information.
Professional	59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	6 - The procedure/revenue code is inconsistent with the patient's age.	N129 - This amount represents the dollar amount not eligible due to the patient's age.
Professional	133 - The disposition of this claim/service is pending further review.	M47 - Missing/incomplete/invalid internal or document control number.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N54 - Claim information is inconsistent with pre-certified/authorized services.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95 - This provider type/provider specialty may not bill this service.
Professional	146 - Diagnosis was invalid for the date(s) of service reported.	MA63 - Missing/incomplete/invalid principal diagnosis.
Professional	8 - The procedure code is inconsistent with the provider type/specialty (taxonomy).	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
Professional	18 - Duplicate claim/service.	N30 - Recipient ineligible for this service.
Professional	#N/A	N129 - Not eligible due to the patient's age.

Professional	45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N48 - Claim information does not agree with information received from other insurance carrier.
Professional	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	M20 - Missing/incomplete/invalid HCPCS.
Professional	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M80 - Not covered when performed during the same session/date as a previously processed service for the patient.
Professional	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	M20 - Missing/incomplete/invalid HCPCS.
Professional	22 - This care may be covered by another payer per coordination of benefits.	N36 - Claim must meet primary payer's processing requirements before we can consider payment.
Professional	18 - Duplicate claim/service.	M86 - Service denied because payment already made for similar procedure within set time frame.
Professional	22 - This care may be covered by another payer per coordination of benefits.	N36 - Claim must meet primary payer's processing requirements before we can consider payment.
Professional	59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	9 - The diagnosis is inconsistent with the patient's age.	N129 - This amount represents the dollar amount not eligible due to the patient's age.
Professional	24 - Charges are covered under a capitation agreement/managed care plan.	N130 - Consult plan benefit documents for information about restrictions for this service.
Professional	109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N193 - Specific federal/state/local program may cover this service through another payer.
Professional	133 - The disposition of this claim/service is pending further review.	N198 - Rendering provider must be affiliated with the pay-to provider.
Professional	B22 - This payment is adjusted based on the diagnosis.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	181 - Procedure code was invalid on the date of service.	M119 - Missing/incomplete/invalid National Drug Code (NDC).

Professional	45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N36 - Claim must meet primary payer?s processing requirements before we can consider payment.
Professional	22 - This care may be covered by another payer per coordination of benefits.	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.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N185 - Do not resubmit this claim/service.
Professional	133 - The disposition of this claim/service is pending further review.	N29 - Missing documentation/orders/notes/summary/report/chart.
Professional	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.)	N286 - Missing/incomplete/invalid referring provider primary identifier.
Professional	22 - This care may be covered by another payer per coordination of benefits.	N36 - Claim must meet primary payer?s processing requirements before we can consider payment.
Professional	22 - This care may be covered by another payer per coordination of benefits.	N36 - Claim must meet primary payer?s processing requirements before we can consider payment.
Professional	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.)	M119 - Missing/incomplete/invalid National Drug Code (NDC).
Professional	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.	N185 - Do not resubmit this claim/service.
Professional	22 - This care may be covered by another payer per coordination of benefits.	N196 - Patient eligible to apply for other coverage which may be primary.
Professional	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	M20 - Missing/incomplete/invalid HCPCS.
Professional	133 - The disposition of this claim/service is pending further review.	N10 - Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.

Professional	B5 - Coverage/program guidelines were not met or were exceeded.	N130 - Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
Professional	31 - Patient cannot be identified as our insured.	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
Professional	146 - Diagnosis was invalid for the date(s) of service reported.	MA63 - Missing/incomplete/invalid principal diagnosis.
Professional	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.)	N192 - Patient is a Medicaid/Qualified Medicare Beneficiary.
Professional	133 - The disposition of this claim/service is pending further review.	N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.
Professional	7 - The procedure/revenue code is inconsistent with the patient's gender.	M51 - Missing/incomplete/invalid procedure code(s) and/or rates.
Professional	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.)	N30 - Recipient ineligible for this service.
Professional	15 - The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62 - Missing/incomplete/invalid treatment authorization code.
Professional	133 - The disposition of this claim/service is pending further review.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	13 - The date of death precedes the date of service.	N30 - Recipient ineligible for this service.
Professional	109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N193 - Specific federal/state/local program may cover this service through another payer.
Professional	B22 - This payment is adjusted based on the diagnosis.	M76 - Missing/incomplete/invalid diagnosis or condition.
Professional	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.)	M119 - Missing/incomplete/invalid National Drug Code (NDC).

Professional	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.	N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
Professional	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.
Professional	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	M20 - Missing/incomplete/invalid HCPCS.
Professional	181 - Procedure code was invalid on the date of service.	M119 - Missing/incomplete/invalid National Drug Code (NDC).
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N185 - Do not resubmit this claim/service.
Professional	133 - The disposition of this claim/service is pending further review.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	B5 - Coverage/program guidelines were not met or were exceeded.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	17 - Requested information 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.)	N379 - Claim level information does not match line level information.
Professional	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N36 - Claim must meet primary payer's processing requirements before we can consider payment.
Professional	17 - Requested information 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.)	N379 - Claim level information does not match line level information.

Professional	133 - The disposition of this claim/service is pending further review.	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
Professional	31 - Patient cannot be identified as our insured.	N365 - This procedure code is not payable. It is for reporting/information purposes only.
Professional	31 - Patient cannot be identified as our insured.	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.
Professional	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.)	M51 - Missing/incomplete/invalid procedure code(s) and/or rates.
Professional	31 - Patient cannot be identified as our insured.	MA61 - Missing/incomplete/invalid social security number or health insurance claim number.
Professional	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	M20 - Missing/incomplete/invalid HCPCS.
Professional	133 - The disposition of this claim/service is pending further review.	M17 - 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.
Professional	B13 - Previously paid. Payment for this claim/service may have been provided in a previous payment.	M47 - Missing/incomplete/invalid internal or document control number.
Professional	181 - Procedure code was invalid on the date of service.	MA66 - Missing/incomplete/invalid principal procedure code or date.
Professional	29 - The time limit for filing has expired.	N59 - Please refer to your provider manual for additional program and provider information.
Professional	133 - The disposition of this claim/service is pending further review.	N10 - Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.

Professional	97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M80 - Not covered when performed during the same session/date as a previously processed service for the patient.
Professional	24 - Charges are covered under a capitation agreement/managed care plan.	M52 - Missing/incomplete/invalid from date(s) of service.
Professional	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.)	MA100 - Missing/incomplete/invalid date of current illness, injury or pregnancy.
Professional	22 - This care may be covered by another payer per coordination of benefits.	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.
Professional	31 - Patient cannot be identified as our insured.	M76 - Missing/incomplete/invalid diagnosis or condition.
Professional	59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N198 - Rendering provider must be affiliated with the pay-to provider.
Professional	204 - This service/equipment/drug is not covered under the patient's current benefit plan	N30 - Recipient ineligible for this service.
Professional	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.)	N30 - Recipient ineligible for this service.
Professional	22 - This care may be covered by another payer per coordination of benefits.	N196 - Patient eligible to apply for other coverage which may be primary.
Professional	133 - The disposition of this claim/service is pending further review.	N10 - Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.

Professional	B5 - Coverage/program guidelines were not met or were exceeded.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	31 - Patient cannot be identified as our insured.	N95 - This provider type/provider specialty may not bill this service.
Professional	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.)	M54 - Missing/incomplete/invalid total charges.
Professional	133 - The disposition of this claim/service is pending further review.	N198 - Rendering provider must be affiliated with the pay-to provider.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95 - This provider type/provider specialty may not bill this service.
Professional	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.)	MA31 - Missing/incomplete/invalid beginning and ending dates of the period billed.
Professional	10 - The diagnosis is inconsistent with the patient's gender.	MA63 - Missing/incomplete/invalid principal diagnosis.
Professional	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	22 - This care may be covered by another payer per coordination of benefits.	N196 - Patient eligible to apply for other coverage which may be primary.
Professional	22 - This care may be covered by another payer per coordination of benefits.	#N/A
Professional	182 - Procedure modifier was invalid on the date of service.	M20 - Missing/incomplete/invalid HCPCS.
Professional	45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).	N48 - Claim information does not agree with information received from other insurance carrier.

Professional	B22 - This payment is adjusted based on the diagnosis.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	133 - The disposition of this claim/service is pending further review.	N198 - Rendering provider must be affiliated with the pay-to provider.
Professional	31 - Patient cannot be identified as our insured.	N130 - Consult plan benefit documents for information about restrictions for this service.
Professional	29 - The time limit for filing has expired.	N59 - Please refer to your provider manual for additional program and provider information.
Professional	18 - Duplicate claim/service.	M86 - Service denied because payment already made for similar procedure within set time frame.
Professional	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.)	N65 - Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
Professional	11 - The diagnosis is inconsistent with the procedure.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service.	N95 - This provider type/provider specialty may not bill this service.
Professional	4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.	N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
Professional	13 - The date of death precedes the date of service.	N30 - Recipient ineligible for this service.

Description
Claim/Service is a duplicate of a previously paid claim.
The provider is unable to bill for this procedure based on their enrollment specialty.
Beneficiary is enrolled in a Medicaid Health Plan.
Rendering Provider must be associated to the Billing/ Pay-to Provider.
Beneficiary's assigned benefit plan receives no payment. Eligibility should be verified.
Rendering Provider must be associated to the Billing/ Pay-to Provider.
Beneficiary's assigned benefit plan receives no payment. Eligibility should be verified.
Unable to determine the beneficiary's benefit plan.
The provider is unable to bill for this procedure based on their enrollment specialty.
Billing or Pay-to Provider missing from claim.
Provider not active or enrolled on date of service billed.
Claim/Service is a duplicate of a previously paid claim.
Services billed exceed program limitations.
Services billed exceed program limitations.
Provider not active or enrolled on date of service billed.
The provider is unable to bill for services covered by this beneficiary's benefit plan due to the providers specialty/subspecialty.

The beneficiary has other insurance which must be billed prior to Medicaid.
Billing or Pay-to Provider missing from claim.
Provider not active or enrolled on date of service billed.
Services not covered for beneficiaries age 21 and older.
Procedure code not valid for beneficiaries age.
Procedure rate can not be determined or is not on file for the date of service reported.
The diagnosis code reported is not valid for the beneficiary's benefit plan.
The Medicare deductible amount reported is invalid.
Procedure or Revenue code are not covered by MDCH on the date of service.
The required CLIA number is missing.
Beneficiary is enrolled in a Medicaid Health Plan.
Provider not active or enrolled on date of service billed.
The place of service billed is incorrect or non-covered based on the beneficiary's benefit plan.
This service is not covered by MDCH for the date of service.

The combination of services billed exceeds the established program limitation.

The combination of services billed exceeds the established program limitation.

Claim/Service is being reviewed as a possible duplicate of a previously paid claim.

The place of service billed is incorrect or non-covered based on the beneficiary's benefit plan.

The required CLIA number is missing.

Unable to determine the beneficiary's benefit plan.

The procedure code billed is incorrect or non-covered based on the beneficiary's benefit plan.

Invalid or missing original TCN.

Invalid or missing original TCN.

The provider is unable to bill for services covered by this beneficiary's benefit plan due to the providers specialty/subspecialty.

The diagnosis code reported does not support the procedure.

Information on the claim does not match the service on the prior authorization.
Claim information is inconsistent with the submitted prior authorization number.
The dates of service are not within the prior authorization dates of service.
The diagnosis pointer is invalid.
The time limit for filing has expired.
A combination of services billed for the same date are being reviewed.
Payment for this service is included in another paid service on the same date.
Procedure code not valid for beneficiaries age.
Invalid or missing original TCN.
CSHCS has not authorized this provider to render treatment to this beneficiary.
Provider not active or enrolled on date of service billed.
Diagnosis code is invalid for the date of service.
The provider is unable to bill for this procedure based on their enrollment specialty.
Claim/Service is a duplicate of a previously paid claim.
Services not covered for beneficiaries age 21 and older.

The Medicare deductible amount reported is invalid.
The procedure code is inconsistent with the modifier submitted or a required modifier is missing.
Payment for this service is included in another paid service on the same date.
The procedure code is inconsistent with the modifier submitted or a required modifier is missing.
The Claim Adjustment Reason codes supplied by the primary payer are being reviewed.
Claim/Service is being reviewed as a possible duplicate of a previously paid claim.
The Claim Adjustment Reason codes supplied by the primary payer are being reviewed.
The combination of services billed for the same date of service are being reviewed in accordance with CCI guidelines.
The beneficiary's age is not valid for the diagnosis code.
Beneficiary is enrolled in a Medicaid Health Plan.
Beneficiary is enrolled in a mental health or substance abuse plan.
Billing or Pay-to Provider missing from claim.
The submitted diagnosis code requires manual review.
Invalid HCPCS and NDC combination.

Your claim can not be processed based on the adjustment reason codes supplied by the primary payer.

The beneficiary has other insurance which must be billed prior to Medicaid.

Provider was inactive or not enrolled on the claim date of service.

Code reported on the claim requires manual review.

Referring Provider NPI missing.

Claim is being reviewed for possible Medicare coverage.

Claims is being reviewed for possible change in other insurance status.

Invalid National Drug Code (NDC).

The units or dollars for the submitted prior authorization number have been exhausted.

The beneficiary is 65 or older and eligible for Medicare but there is no Medicare information on the claim.

The modifier reported is inconsistent with the procedure code billed.

This claim is suspending further review as a result of the provider requesting individual consideration.

Services billed exceed program limitations.

The procedure code billed is incorrect or non-covered based on the beneficiary's benefit plan.

Diagnosis code is invalid for the date of service.

This is a Qualified Medicare Beneficiary (QMB) and services billed were not covered by Medicare.

The procedure code billed is not correct or valid for the date of service billed.

Beneficiary's gender is not valid for the procedure or revenue code billed.

The principal diagnosis code reported is not covered for the Plan First benefit plan.

Prior Authorization number is missing or invalid.

Code on claims requires documentation.

The beneficiary's date of death is before the date of service on the claim.

Beneficiary is enrolled in a mental health or substance abuse plan.

The diagnosis pointer is invalid.

Invalid National Drug Code (NDC).

Original TCN has already been adjusted.

Missing, incomplete, or invalid place of service.

The procedure code is inconsistent with the modifier submitted or a required modifier is missing.

Invalid HCPCS and NDC combination.

Provider was inactive or not enrolled on the claim date of service.

The amount to be paid for this service is being determined manually.

Services are being billed in excess of the established program limitation.

The corresponding line on the original TCN denied.

The modifier reported is invalid for the service billed.

Your claim can not be processed based on the adjustment reason codes supplied by the primary payer.

The currently number of claim lines does not match the original TCN.

Procedure rate can not be determined or is not on file for the date of service reported.

Beneficiary's assigned benefit plan receives no payment. Eligibility should be verified.

Unable to determine the beneficiary's benefit plan due to incomplete or invalid claim information.

Missing, incomplete, or invalid procedure code.

Beneficiary ID in missing or invalid.

The modifier reported is invalid for the service billed.

Required beneficiary identification information is missing or invalid.

Original TCN has already been adjusted.

Invalid procedure code on the date of service.

The time limit for filing has expired.

This claim is suspending further review as a result of the provider requesting individual consideration.

A component part of the procedure billed was previously paid on another claim.

The date of service on this is too old to be processed by CHAMPS and will be reviewed manually.

The related cause date is missing, incomplete, or invalid.

The beneficiary has other insurance which must be billed prior to Medicaid.

The diagnosis code reported is not valid for the beneficiary's benefit plan.

The combination of services billed for the same date of service are being reviewed in accordance with CCI guidelines.

Rendering Provider must be associated to the Billing/ Pay-to Provider.

Procedure or Revenue code are not covered by MDCH on the date of service.

The principal diagnosis code reported is not covered for the Plan First benefit plan.

The beneficiary is 65 or older and eligible for Medicare but there is no Medicare information on the claim.

This claim is suspending further review as a result of the provider requesting individual consideration.

The combination of services billed exceeds the established program limitation.

The provider is unable to bill for services covered by this beneficiary's benefit plan due to the providers specialty/subspecialty.

The sum of the line charges does not equal the total claim charge.

Billing or Pay-to Provider missing from claim.

Provider not active or enrolled on date of service billed.

The dates of service from or to date is missing or invalid.

The beneficiary's gender is not valid for the reported diagnosis code.

The submitted modifier is pending for review.

The beneficiary is 65 or older and eligible for Medicare but there is no Medicare information on the claim.

An invalid procedure code was reported by the primary payer on the service line.

The procedure code modifier is not a valid HCPCS modifier.

The Medicare deductible amount reported is invalid.

The submitted diagnosis code requires manual review.

Billing or Pay-to Provider missing from claim.

Unable to determine the beneficiary's benefit plan.

The time limit for filing has expired.

Claim/Service is being reviewed as a possible duplicate of a previously paid claim.

This service is not covered by MDCH for the date of service.

The diagnosis code reported does not support the procedure.

Provider not active or enrolled on date of service billed.

The reported procedure code modifier is invalid for the service.

The beneficiary's date of death is before the date of service on the claim.