MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: All Provider 01-08

Issued: August 1, 2001

Subject: Explanation Codes Appendix

Effective: Upon Receipt

Programs Affected: Medicaid, Children's Special Health Care Services, State Medical Program

Attached is an updated list of remittance advice explanation codes. It replaces the current Appendix D (Explanation Codes) in your Medicaid manual.

Manual Maintenance

Providers should discard the current Appendix D and insert the Explanation Codes Appendix.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@state.mi.us. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved

James K. Haveman, Jr.
Director

Robert M. Smedes
Deputy Director for
Medical Services Administration

Current Change	Code Number	Terminology
	006	**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.
	007	**The provider has not submitted a complete cost report or has failed to provide other documentation requested by the Medical Services Administration.**
Addition	008	**HBP invoice adjustment.**
Addition	011	**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 office of your correct TIN**.
	013	**The claim was submitted electronically and there is no authorization for this billing agent from the provider on file with Provider Enrollment.** The provider mu st submit a completed MSA -1343 to Provider Enrollment, wait for verification of receipt of the MSA -1343 (on the Provider Turn -Around form), and then rebill the claim.
	014, 015	**The date of service is more than 180 days from the Julian Date of the Prior Authorization Number.**
	019	**The beneficiary ID Number is missing.** The claim should be corrected and rebilled.
	020	**The beneficiary ID Number is not numeric.** The provider should verify the beneficiary ID Number. The claim should be corrected and rebilled.
	021	**The beneficiary ID Number is invalid.** The provider should verify the beneficiary ID Number. The claim should be corrected and rebilled.
	022	**The beneficiary ID Number does not match any beneficiary ID Number on the eligibility verification system.**
	023	**The beneficiary was not eligible for Medicaid or State Medical Program coverage on the date(s) of service.**
	024	**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.
Revision	025	**The beneficiary is enrolled in a Medicaid Health Plan.** The provider s hould contact the Medicaid Health Plan for reimbursement.
	026	**The beneficiary is eligible for Children's Special Health Care Services Program coverage on the date of service.** The explanation code is for informational purposes only.
	027	**The beneficiary is eligible for both Children's Special Health Care Services and Medicaid coverage on the date(s) of service.** The explanation code is for informational purposes only.
	029	**The beneficiary is eligible for State Medical Program coverage on the date(s) of service**. The explanation code is for informational purposes only.

Current Change	Code Number	Terminology
	037	**Reimbursement for a Resident County Hospitalization claim(s) must be obtained from the beneficiary's local Family Independence Agency office, not Medicaid.** The provider should contac t the local Family Independence Agency office.
	038	**The local Family Independence Agency office has not entered the proper authorization on the eligibility verification system.**
	040	**The principle diagnosis code is missing.** The claim should be correcte d and rebilled.
	041	**The principle diagnosis code does not match the diagnosis file.**
	042	**The principle diagnosis code is under review for Program criteria.**
	044	**The other diagnosis code is under review for Program criteria.**
	045	**The principle diagnosis code is being manually reviewed as the beneficiary's age does not fall within the normally accepted age range for this diagnosis.**
	046	**The principle diagnosis code is being manually reviewed as the diagnosis is not normally acceptable for the beneficiary's sex.**
	049	**The principle diagnosis code is being manually reviewed.**
	050	**The principle diagnosis code is being manually reviewed as this type of provider does not normally render treatment for this diagnosis.**
	051	**The procedure code billed does not reflect the appropriate treatment for the principle diagnosis.**
	058	**The procedure code billed does not reflect the appropriate treatment for the secondary diagnosis**.
	059	**The other diagnosis code is being manually reviewed as this type of provider does not normally render treatment for this diagnosis.**
	061	**The other diagnosis code does not match the diagnosis file.**
	062	**The other diagnosis code is being manually reviewed as this type of provider does not normally render treatment for this diagnosis.**
	063	**The other diagnosis code is being manually reviewed as the diagnosis is not normally acceptable for the beneficiary's sex.**
	064	**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.**
	065,066,067	**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.**
	068	**The claim is being reviewed for a prior authorization condition.**
	073	**The tooth number/letter is invalid.** The claim should be corrected and rebilled.
	074	**The tooth surface is invalid.** The claim should be corrected and rebilled.

Current Change	Code Number	Terminology
	075	**The tooth number/letter is required.** The claim should be corrected and rebilled.
	076	**The tooth surface is missing.** The claim should be corrected and rebilled.
	078	**The quantity on the claim exceeds the allowable quantity for this procedure code.** The explanation code is for informational purposes only.
	079	**The injury code is missing.** The claim should be corrected and rebilled.
	080	**The injury code is invalid.** The injury code should be corrected and the claim should be rebilled.
	087	**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, Medical Services Administration, 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.
	088	**The copayment has been deducted for chiropractic, podiatric, or hearing aid services.** The explanation code is for informational purposes only.
Revision	089	**The required procedure or revenue code is missing.** The claim should be corrected and rebilled.
	090	**The type of service code is missing or invalid.** The claim should be corrected and rebilled.
	091	**Incomplete or invalid procedure code.** The claim should be corrected and rebilled.
Revision	092	**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.
	093	**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. Providers should also verify the billing procedure with current manual material for possible changes. The claim should be corrected and rebilled.
	095	**The place of service is not acceptable for this procedure code or type of service.**
	096	**The procedure code is being manually reviewed as the beneficiary's age does not fall within the normally accepted age range for the procedure.**
	097	**The procedure code is being manually reviewed as the procedure is not normally acceptable for the beneficiary's sex.**
	099	**The procedure code is being manually reviewed as this type of provider does not normally render the indicated procedure.**
	100	**The amount to be paid for this procedure is being determined manually.**

Current Change	Code Number	Terminology
	101	**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. The explanation code is for informational purposes only.
	102	**The amount billed is being manually reviewed.**
	103	**The amount to be paid on this claim is different than the total Medicare coinsurance and/or deductible amounts.**
	104	**This procedure code or drug code is being manually reviewed for Program criteria.**
	105	**This service may have a comprehensive/component or a mutually exclusive relationship with another service billed for the same date.**
	107	**The sum of Medicare and other insurance payments equals or exceeds Medicaid's rate.** The service should **not** be rebilled.
	110	**The level of care shown on the claim does not match the level of care on eligibility verification system for this beneficiary.**
	116	**Medicare coverage may be available when a diagnosis or procedure is for chronic renal disease.**
	119	**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.
	120	**The primary surgical procedure code is invalid.** The claim should be corrected and rebilled.
	121	**The primary surgical procedure code does not match the procedure file.** The claim should be corrected and rebilled.
	122	**Operating room charges were billed without a primary surgical procedure code.** The claim should be corrected and rebilled.
	125	**The secondary surgical procedure code is invalid.** The secondary surgical procedure code should be corrected and the claim should be rebilled.
	126	**The secondary surgical procedure code does not match the procedure file.** The provider should correct the secon dary surgical procedure code and rebill the claim.
	127	**The surgical procedure is being reviewed because of an emergent or urgent condition.**
	130	**The individual consideration code is invalid.** The explanation code is for informational purposes only.
	132	**The disposition of this claim/service is pending further review.**
	136	**The attending physician provider ID Number is missing.** The provider should enter the correct attending physician provider ID number and rebill.
	137	**The attending physician provider ID Number is invalid.** The claim should be corrected and rebilled.

Current Change	Code Number	Terminology
	140	**The beneficiary was eligible for State Medical Program coverage on the date of service but no authorization from the local Family Independence Agency office is on file for the service.** If the provider did receive authorization from the local Family Independence Agency office, the claim may be rebilled with a copy of the authorization attached.
	141	**This type of provider is not authorized to provide treatment under the State Medical Program.**
	142	**The place of service is not acceptable for the State Medical Program.** The service must not be rebilled.
	143	**The procedure or drug code is not covered for the State Medical Program.**
	147	**The provider type is not authorized to provide treatment under Resident County Hospitalization.** (Only types 10, 11, 13, 14, 30, and 74 are allowed provider types.)
	148	**The place of service is not acceptable by the Resident County Hospitalization Program.** (Only the inpatient place of service is acceptab le.)
	150	**Did not complete or enter accurately the ordering/referring provider ID number.** The claim should be corrected and rebilled.
	151	**Did not complete or enter accurately the ordering/referring provider ID number.** The claim should be corrected and rebilled.
	152	**The ordering/referring physician ID Number is being reviewed.** The explanation code is for informational purposes only.
	153	**The pharmacy copayment has been deducted.** The explanation code is for informational purposes only.
	154	**The date of service is missing.** The claim should be corrected and rebilled.
	155	**The date of service is invalid.** The claim should be corrected and rebilled.
	156	**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.
	157	**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.
	158	**The claim was received by the Department of Community Health more than one year after the date of service.**
	161	**The provider is a hospital-based physician.** The explanat ion code is for informational purposes only.
	162	**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 comple ting a residency in the specialty area, along with his/her provider ID Number, to the Provider Enrollment Unit.
	164	**The admission date is missing.** The claim should be corrected and rebilled.
	165	**The admission date is invalid.**

Current Change	Code Number	Terminology
	166	**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.
	167	**The Resident County Hospitalization Program does not cover this dental procedure.**
	168	**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. The explanation code is for informational purposes only.
	169	**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.**
	170	**The provider ID Number on the claim does not match the provider ID Number on the prior authorization form on file with the Department of Community Health.** The explanation code is for informational purposes only.
	171	**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.**
	173	**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.
	174	**The begin date of service is missing.** The claim should be corrected and rebilled.
	175	**The begin date of service is invalid.**
	176	**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 data is correct, the service must not be rebilled.
	177	**The tooth surface on the Dental Invoice does not match the tooth surface on the prior authorization form on file with the Department of Community Health.** The provider should verify the tooth surface billed with the surface that was prior authorized. If they match, the provider should contact the dental consultant.
	178	**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**.
	180	**The procedure code billed has been deleted from the prior authorization form on file with the Department of Community Health.**
	181	**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.
	183	**The date of service is prior to the date of the prior authorization.**
	184	**The end date of service is missing.** The claim should be corrected and rebilled.

Current Change	Code Number	Terminology
Revision	185	**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 thru dates on the claim.**
	186	**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.
	187	**The range from begin to end date of service covers more than one month.** The provider should rebill each month on a separate claim.
	188	**There is no authorization for long-term care on eligibility verification system for at least one of the dates covered by this claim.**
	190	**The prior authorization number is not numeric.** The claim should be corrected and rebilled.
	191	**The prior authorization number is invalid.**
	192	**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.
	193	**The Children's Special Health Care Services Program has not authorized this date of service.**
	194	**The Children's Special Health Care Services Program has not authorized this provider type to render treatment to this child.**
	195	**The Children's Special Health Care Services Program has not authorized this provider ID Number to render treatment to this child.**
	197	**The service requires prior authorization and the prior authorization number is not on the claim.**
	199	**The procedure was reimbursed at the lesser of charge or screen.** The explanation code is for informational purposes only.
	201	**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 pr ovider ID number.
	202	**Medicaid has been billed before six months have elapsed since billing the other insurance carrier.** The provider should wait until six months after billing the other insurance carrier before rebilling the claim.
	203	**The provider must bill the other insurance carrier first for ancillary services.** (The eligibility verification system indicates that the beneficiary has other insurance but the claim indicates no action was taken by the other insurance carrier.) The provider should bi ll the other insurance carrier, await a response, then rebill the claim.
	209	**The vision copayment has been deducted.** The explanation code is for informational purposes only.
	210	**The required replacement claim or adjustment has an invalid original claim reference number.**
	211	**The required original claim reference number is missing from the replacement claim or adjustment.** The claim should be corrected and rebilled.

Current Change	Code Number	Terminology
	213	**The adjustment has an invalid original claim line number.**
	214	**The required original claim line number is missing from the adjustment.**
	215	**The adjustment invoice amount billed is not equal to zero.**
	216	**The Medicaid Health Plan has billed too far in advance**. The date(s) should be verified. If incorrect, the claim should be correc ted and rebilled.
	217	**The end date of service does not equal the last day of the month.**
	218	T**he begin date of service does not equal the first day of the month.**
	219	**The primary surgical procedure date is invalid.**
	220	**The primary surgical procedure date is missing.** The claim should be corrected and rebilled.
	222	**The prescription number is missing.** The claim should be corrected and rebilled.
	223	**The prescription number is invalid.**
	224	**The beneficiary is restricted to primary providers as indicated on the beneficiary's ID Card.**
	225	**The beneficiary requires prior authorization as indicated on the beneficiary's ID Card.**
	228	**The pharmacy's prescribing/referring physician is not the restricted beneficiary's primary provider as indicated on the beneficiary's ID Card.**
	229	**The required emergent condition code is missing.** The claim should be corrected and rebilled.
	230	**The emergent condition code is invalid.**
	231	**Begin date of service prior to implementation of Medicaid Health Plan.**
	233	**The referral code is missing.** The claim should be corrected and rebilled.
	234	**The referral code is invalid.**
	235	**The provider ID and the procedure code billed are not compatible.**
	236	**The beneficiary was not enrolled in a Medicaid Health Plan on the date(s) of service.**
	238	**The locator code is invalid.**
	239	**The Medicare status code is missing.** The claim should be corrected and rebilled.
	240	**The Medicare status code is invalid.**
Addition	241	**The disposition of this claim is pending further review.**

Current Change	Code Number	Terminology
	242	**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.**
	243	**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.**
	244,245	**The claim is being reviewed for possible Medicare coverage.**
	246	**The beneficiary is eligible for Medicare, however, the claim shows the beneficiary is under age 65.**
	247	**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.**
	251	**The facility is billing for ancillary services that have not been approved by Medicare.** Only those ancillary services with a coinsurance or deductible amount may be billed by the facility. The service must not be rebilled.
	252	**The modifier or the type of service submitted on this claim is inconsistent with authorized services.**
	254	**The other insurance code is missing.** The claim should be corrected and rebilled.
	255	**The other insurance code is invalid.**
Revision	258	**Our records indicate there is insurance primary to ours; however you did not complete or enter accurately the required information.**
	262	**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 using the correct other insurance code and documentation.
	264	**The discharge status code is missing**. The claim should be corrected and rebilled.
	265	**The discharge status code is invalid.**
	269	**The claim is being manually reviewed for possible change in other insurance status.**
	271	**The Medicaid Health Plan beneficiary has other insurance.** The explanation code is for informational purposes only.
	272, 273	**The beneficiary has another insurance coverage for pharmacy.** The pharmacy must bill the Other Insurance carrier first before billing Medic aid, Children' s Special Health Care Services, or the State Medical Program. See your Pharmacy Manual Appendix C for requirements regarding Other Insurance billings and Chapter IV for billing instructions for prescriptions with Other Insurance payments. Beneficiary ID cards will indicate an Other Insurance Code of 87 or 89 when a beneficiary has another pharmacy insurer.

Current Change	Code Number	Terminology
	276	**The sum of the amounts paid by the other insurance carrier does not equal the total other insurance amount paid.** The provider shou ld recalculate the dollar amount on each claim line. The total of the other insurance payment on each claim line must equal the total other insurance payment item. The claim should be corrected and rebilled. (The provider may rebill indicating a lump su m other insurance payment in the Remarks section or Total Other Insurance Paid item. A copy of the other insurance's payment voucher must accompany the claim.)
	277	**The sum of the amounts billed does not equal the total amount billed.** The provider shoul d correct the dollar amounts on each claim line and rebill the claim.
	278	**The noncovered charge is greater than the beneficiary-pay amount.** The explanation code is for informational purposes only.
	279	**The claim line date of service is not included in the range of dates indicated by the from and thru dates on the claim.** The claim should be corrected and rebilled.
	280	**The surgeon's provider ID Number is invalid.**
	282	**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.
	284	**State-owned and -operated facilities are not allowed to offset beneficiary-pay amounts.** The service must not be rebilled.
	287	**State-owned and -operated facilities may not bill for services that have been applied to the Medicare Part B deductible.** The claim should not be rebilled.
	288	**The relationship between the claim status code and discharge status code is invalid.** The claim should be corrected and rebilled.
	292	**This beneficiary is not authorized for long-term care for these dates of service.** The claim should not b e rebilled.
	294	**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.
	295	**The claim status code is invalid or missing.** The claim should be corrected and re billed.
	296	**The relationship between the claim status code and the admission begin date is invalid.** The claim should be corrected and rebilled.
	298	**The relationship between the Medicare indicator and the beneficiary's age is invalid.** The claim should be corrected and rebilled.
	299	**Ancillary services may not be billed to Medicaid by state-owned and -operated facilities.** The claim should not be rebilled.
	301	**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.
	302	**Outpatient services for beneficiaries in a long-term care facility are limited to ancillary services.** The service must not be rebilled.

Current Change	Code Number	Terminology
	303	**The Medicare indicator is invalid.** The claim should be corrected and rebilled.
	306	**Pharmacies cannot bill over-the-counter products that are included in the facility's per diem rate for a beneficiary in a long-term care facility.** The service must not be rebilled.
	308	**Payment was forced for this enrollee who lost Medicaid eligibility for this month.** The explanation code is for informational purposes only.
	309	**The first date of service may not be a therapeutic leave day.**
	310	**The service is included in the long-term care facility's per diem rate.**
	313	**The last date of service cannot be a therapeutic leave day.**
	314	**The coinsurance amount plus deductible amount is greater than the amount billed on the Medicare lines.** The provider should verify the amount used with the Medicare voucher and correct and rebill the claim.
	315	**The date the claim was submitted to the other insurance carrier is invalid.** The explanation code is for informational purposes only.
	317	**The relationship between the beneficiary's level of care and the provider type is invalid.**
	319	**This is a continuous or final billing for outpatient services.**
	320	**The relationship between Medicare indicator on claim lines 6 through 10 and the information on the claim line may be invalid as:** ➢ **the indicator is blank, which is to be used for claims with Medicare (T18) payment, and no claim line Medicare payment is shown, or** ➢ **the indicator is "2", which is to be used for claims without Medicare payment, and a claim line Medicare payment is shown.**
	321	**The procedure is being reviewed as a separate procedure.**
	322	**The noncovered charges are not prior authorized.** The service must not be rebilled.
	323, 325	**Multiple procedures are being reviewed for appropriate reimbursement.**
	324	**Multiple procedures will be reimbursed based on claim line order with the primary procedure first.**
	327	**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 rebill ed until the Provider Enrollment file is updated.
	328	**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.
	329	**The number of days or visits is missing.** The claim should be corrected and rebilled.
	330	**The number of days or visits is invalid**.

Current Change	Code Number	Terminology
	331	**The relationship between the number of days billed, the from and thru dates, and discharge status code is invalid.** The cla im should be corrected and rebilled.
	332	**The total number of days billed does not equal the sum of the days on the claim lines.**
	333	**This procedure code cannot be used by this provider.** The service should not be rebilled.
	334	**Days supply is invalid or missing.** The claim should be corrected and rebilled.
	336	**Days supply is greater than 100 days.** The service must not be rebilled.
	337	**The compounded indicator was changed to 1, as the value submitted was invalid.** Valid values are 4 (home infusion t herapy), 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.
	338	**The procedure code requires prior authorization when billed with this diagnosis.**
	339	**Replacement claim or adjustment pending for determination of compliance with prior authorization requirements.**
	341	**This laboratory service is not allowed for this provider type.** The service must not be rebilled.
	342	**A unit dose fee has been approved for this provider.** The explanation code is for informational purposes only.
	343	**This procedure is being manually reviewed for identification of the referring/attending provider.** The explanation code is for informational purposes only.
	344	**Required referring/attending provider ID number is missing or invalid.** The claim should be corrected and rebilled.
	348	**This service has been reimbursed as a bilateral procedure based on the reporting of Modifier Code 50.** This explanation code is f or informational purposes only.
	349	**Modifier Code 50 has been reported for this procedure, but no additional reimbursement has been made.** This explanation code is for informational purposes only.
	350	**Required place of service code is missing.** The cla im should be corrected and rebilled.
	355	**Required quantity billed is invalid or missing**.
	362	**Missing drug code.** The claim should be corrected and rebilled.
	363	**Invalid drug code.** The claim should be corrected and rebilled.
	364	**The service has been rejected as it was rendered upon an order/prescription from a suspended provider.** The claim must not be rebilled.

Current Change	Code Number	Terminology
	367	**The claim reflects a quantity in excess of the quantity normally accepted for this drug.** This explanation code frequently causes pay ment rejections, because the proper billing unit was not used (e.g. milliliters were used instead of vials). Pharmacies should rebill with corrected quantity entries. When quantity limits are exceeded, a pharmacy may receive payment by rebilling and lis ting the prescriber's daily dosage instruction in the Remarks or Drug Description of the invoice. For dermatologicals, also list the size of the application area. [Note: The prescriber' s daily dosage instruction times the number of Days Supply billed mu st equal the Quantity billed.]
	369	**The drug billed requires prior approval and the required prior authorization number was invalid for the beneficiary.**
	370	**The National Drug Code (NDC) is not on the Program's drug file.** Check the NDC entry for accurac y and rebill.
	371	**The National Drug Code (NDC) billed is not normally dispensed for a beneficiary of this age.**
	372	**The National Drug Code (NDC) billed is not applicable for the beneficiary's sex.** All data should be verified. If appropriate, correctio ns should be made and the claim rebilled. If the data is correct, the service must not be rebilled.
	373	**The compounded drug claim is being manually priced.**
	374	**The amount billed is being manually reviewed.**
	376	**Medicaid, Children's Special Health Care Services or the State Medical Program does not cover the drug billed.** All data should be verified, especially the Michigan Medicaid Drug List (Appendix F). If appropriate, corrections should be made and the prescription rebilled. If the data is correct , the prescription must not be rebilled.
	377	**The new/refill code is missing.** The claim should be corrected and rebilled.
	378	**The new/refill code is invalid.** The claim should be corrected and rebilled.
	379	**The fee for this procedure is being manually reviewed.**
	380	**The acquisition charge is missing.**
	381	**The facility charge is invalid.**
	382	**The quantity times the rate does not equal the hospital charge.**
	383	**The professional charge is missing.** The claim should be corrected and rebilled.
	384	**The professional charge is invalid.** The claim should be corrected and rebilled.
	388	**The diagnosis code does not appear to support the procedure billed.**
	389	**There is an invalid relationship between the number of days billed, the from and thru dates, and the discharge status code.**

Current Change	Code Number	Terminology
	390	**The other insurance payment on this claim line is invalid.**
	392	**The quantity entry and package size for the National Drug Code (NDC) billed are inconsistent.** The pharmacy should check the quantity entry on the claim to ma ke sure that decimals were billed for fractional package sizes (e.g. 18.1 gms) or that the quantity relates to the NDC package (e.g., billing 21, not 28, for an oral contraceptive sold in packages of 21).
	394	**Inpatient hospital services for Wayne County Resident County Hospitalization beneficiaries require prior authorization by the Wayne County PLUS CARE Program.**
	395	**The amount billed on this claim line is missing.**
	396	**The charges minus Medicare and other insurance payment(s) do not equal the amount billed.** The explanation code is for informational purposes only.
	397	**The charges minus Medicare and other insurance payment(s) do not equal the amount billed.**
	398	**Number of claim lines greater than 1.**
	400	**The total number of lines is invalid.** The e xplanation code is for informational purposes only.
	401	**The total number of lines is missing.** The explanation code is for informational purposes only.
	402	**The number of claim lines read does not equal the total number of lines indicated.** The explanat ion code is for informational purposes only.
	403, 407, 409	**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.
	404	**The claim is being manually reviewed for possible change in other insurance status.**
	408	**The claim is being manually reviewed for possible change in other insurance status.**
	410	**The Medicare payment is invalid**.
	411	**The claim is being manually reviewed for possible change in other insurance status**.
	415	**The Medicare coinsurance amount is invalid.**
	416	**The amount billed as Medicare coinsurance is not calculated correctly based on the total Medicare payment.**
	417	**This elective service (Emergent Condition Code 2) was performed in the emergency room.** The service should be rebilled using the clinic visit Procedure Code 169525.
	418	**This urgent service (Emergent Condition Code 3) was performed in the emergency room.** The service should be rebilled using the clinic visit Procedure Code 169525.
	420	**The amount applied to the Medicare deductible exceeds the yearly Medicare deductible.**

Current Change	Code Number	Terminology
	421	**The provider is billing a procedure code that is incompatible for the setting and the provider specialty.**
	422	**A hospital charge is not allowed for this procedure, or the procedure performed is not indicated on the claim.**
	423	**The procedure code cannot be billed by the Outpatient Hospital.** The provider must rebill using th e correct claim form.
	424	**This procedure code supports the hospital charge codes; no charge is allowed.** The explanation code is for informational purposes only.
	425	**The total other insurance paid is invalid.**
	426	**Beneficiary not eligible for Medicaid and not covered for SMP because of county of residence.** The provider should contact the beneficiary's health care or dental contractor.
	427	**Beneficiary not eligible for Medicaid and not covered for SMP because of county of residence.** The claim should not be rebilled.
	428	**Beneficiary not eligible for Medicaid and not covered for SMP because of county of residence.** The provider should contact the Wayne County Family Independence Agency office.
	429	**Beneficiary not eligible for Medicaid and not covered for SMP because of county of residence.** The claim must not be rebilled.
	432	**The quantity billed is missing or invalid, or the outpatient hospital has asked for individual consideration**.
	433	**The total charge is invalid or missing.**
	434	**The total Medicare payment is not numeric.**
	435	**The total facility charge is invalid.**
	436	**The sum of the hospital charges does not equal the total hospital charge.**
Revision	437	**The sum of the claim line charges does not equal the total charge.**
Revision	438	**The sum of the claim line insurance payments does not equal the total insurance payments**.
Revision	439	**The sum of the claim line insurance payments does not equal the total insurance payments**
	440	**The professional charges total is invalid.**
	441	**The sum of the professional charges does not equal the total professional charge.**
	442	**Wayne County RCH claim received after 10-31-89.**
	443	**Beneficiary not eligible for Medicaid and not covered for SMP because of county of residence.** The service must not be rebilled.
	444	**Services may be the responsibility of the beneficiary's health care or dental contractor in the Wayne County PLUS CARE Program.**
	445	**The total payments from other sources is invalid.**

Current Change	Code Number	Terminology
	446	**The drug requires prior approval and the prior authorization number is missing.** The provider must obtain prior approval and enter the prior authorization number on the claim form.
	447	**The beneficiary is a Qualified Medicare Beneficiary.** This code is for informational purposes only.
	448	**Medicaid is liable only for the coinsurance and deductible portion of a Medicare-covered service for Medicare Qualified Beneficiaries.** The claim must not be rebilled to Medicaid.
	450	**The beneficiary-pay amount is invalid.**
	452	**The claim is pending for manual review of the beneficiary-pay amount.**
	454	**This service is not covered by the Program.** The service must not be rebilled.
	456	**The beneficiary-pay amount less the noncovered charge is not equal to the net beneficiary-pay amount.**
	457	**The claim is being reviewed as the place of service may not be acceptable for this surgery.**
	462	**The beneficiary is only eligible for emergency services and elective services have been billed.** The service must not be rebilled.
Revision	463	**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.
	464	**The total amount billed is missing.** The claim should be corrected and rebilled.
	465	**The total amount billed is invalid.**
	467	**The total net charge minus the net beneficiary-pay amount does not equal the amount billed.** The explanation code is for informational purposes only.
	468	**The summary of the charges does not agree with the total amount billed.**
	469	**The sum of the amounts billed does not equal the total amount billed.** The explanation code is for informational purposes only.
	472	**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.
	473	**The beneficiary is enrolled in the Beneficiary Monitoring Program as requiring prior authorization for services.**

Current Change	Code Number	Terminology
	474	**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.**
	480	**The unit dose repackaging fee was not included in reimbursement because the prescription was not dispensed to a long-term care beneficiary OR the product is not an oral solid OR the product is a manufacturer prepackaged unit dose OR the pharmacy is not authorized for unit dose repackaging reimbursement**. This code is for informational purposes only.
Revision	483	**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.** This code is for informational purposes only.
	486	**The beneficiary no longer resides in the Medicaid Health Plan service area.**
	488	**The Children's Special Health Care Services Program has not authorized this provider type to render services to this child.**
	489	**The beneficiary is not eligible for Medicaid Health Plan enrollment.**
	492	**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.
	494	**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 State Medical Program in those counties where an ID Card is issued.** The explanation code is for informational purposes only.
	495	**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.**
	497	**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.
	498	**This service must be billed with a modifier.** The claim should be rebilled with the appropriate modifier.
	500	**Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.**
	501	**Duplicate procedure between HCPCS and old procedure coding.**
	503	**The date of service on the claim requires manual review.** Adjustments will be processed manually.
	505	**The dates of service span two or more historical processing periods.** Each date of service must be rebilled on a separate claim.

Current Change	Code Number	Terminology
	506	**The services do not reflect the provision of nursing or physical therapy services.**
	508	**Date of Service for Medicaid Health Plan (MHP) claim is too old to be processed.**
	510	**The claim indicates a possible DRG overpayment.**
	511	**The claim indicates an admission to the hospital within 15 days of discharge from a different hospital**.
	513	**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.
	515	**The outpatient claim indicates emergency room services (Procedure Code 169032 or revenue code 450) and subsequent admission to the inpatient hospital setting.**
	517	**Inpatient Hospital claim was not processed by the groups/prices.** The explanation code is for informational purposes only.
	518	**This beneficiary was admitted/hospitalized within 15 days of discharge from a different hospital.**
	519	**This beneficiary was readmitted/rehospitalized to the same hospital within 15 days of discharge.**
	526	**The documentation submitted does not reflect the diagnosis and/or procedure as indicated on the claim. The claim has been reassigned to a new DRG.**
	530	**The outpatient claim is for services provided during an inpatient stay.** These outpatient services must be included on the inpatient claim. The outpatient hospital mu st contact the inpatient hospital for reimbursement for these services.
Addition	532	**Pre-/post-operative care payment is included in the allowance for the surgery/procedure.**
	534	**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**. The explanation code is for informational purposes only. The provider should refund the excess beneficiary -pay amount to the benef iciary and submit a claim adjustment.
	535	**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 Dep artment 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.
	536, 538	**The amount billed for this laboratory service exceeds the dollar limitation established by the Program.**
	540	**Beneficiary enrolled in Healthy Kids Dental Program.** Submit claim to the dental carrier. Do not rebill the Medicaid Program.
	544	**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.

Current Change	Code Number	Terminology
	548	**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.)
	549	**The claim is a duplicate of a claim paid to another Medicaid Health Plan.**
	552	**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.)
	553	**The frequency of this service is being manually reviewed.**
	555	**The date(s) of service is invalid.**
	560	**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.
	562	**Refills of Schedule II drugs are not covered.** The prescription must not be rebilled.
	563	**A refill for a Schedule III, IV, or V drug was billed more than 180 days from the date of service of the original prescription.** A new prescription is required.
	565	**The claim is billing for the sixth refill of the prescription for a Schedule III, IV, or V drug. Only five refills are allowed.** A new prescription must be obtained before the prescription is rebilled.
	567	**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.
	571	**The dates of service for this inpatient claim overlap the dates of service for another paid claim and the amounts billed are equal.**
	572	**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 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.
	574	**The Medicaid Health Plan invoice dates of service overlap the dates of the previously paid claim to another type of provider.**
	575	**The dates of services for this claim are duplicate or overlapping the dates of service for another paid claim.**
	576	**The payment of this Medicare deductible would result in overpayment of the Medicare deductible for the year.**
	577	**More than 18 therapeutic leave days have been used in the last 365 days.**

Current Change	Code Number	Terminology
	579	**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 reje cted, correct the beneficiary pay amount and rebill the adjustment.
	581	**The claim to be adjusted/replaced cannot be located as a paid claim for this beneficiary.**
	582	**An attempt was made to adjust/replace a Claim Reference Number or line number which has already been adjusted/replaced.** Only the last paid Claim Reference Number/line number can be adjusted. The claim adjustment should be rebilled using the last paid Claim Reference Number.
	584	**This is the Claim Reference Number of the claim being adjusted/replaced.** The explanation code is for informational purposes only.
	589	**This fiscal year has been final gross adjusted.**
	590	**The acute dosing coverage for ulcer drugs has been exceeded and no Utilization Review Number has been submitted with the request for payment.** The service must not be rebilled.
	596	**More than one provider type has billed for case management for the same month.** The explanation code is for informational purposes only.
	600	**Determination of reimbursement for the DRG is being made.** The explanation code is for informational purposes only.
	601, 603	**This service may have a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.**
	602	**This service has a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.**
	604	**This service has a comprehensive/component or a mutually exclusive relationship with another service paid for the same date.**
	606	**Multiple procedures or services have been billed on separate claims.**
	607	**The frequency of the combination of services billed exceeds Program policy limits.** The services must not be rebilled.
	608, 609	**The frequency of the combination of services billed exceeds Program Policy Limits. Medical necessity must be documented.**
Addition	670	**Client has private coverage through a managed care organization (MCO). You must bill that MCO. If you are not part of that network you must obtain authorization from that MCO before billing. Medicaid and CSHCS will only cover the co-payment and deductible up to the Medicaid fee.**
Addition	671	**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.**
Addition	672	**The client has met their private insurance co-pay requirement limit for the year. You may bill and receive full reimbursement from the insurance carrier**.
Addition	673	**This service is a covered benefit under the private insurance policy of the client but, to be reimbursed, it requires you to bill the insurance carrier using a more specific diagnosis.**

Current Change	Code Number	Terminology
Addition	674	**This service is a covered benefit under the private insurance policy of the client. Bill the insurance carrier.**
Addition	675	**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.**
Addition	676	**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.**
Addition	677	**The client has a point of service insurance policy. Medicaid requires that the client 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.**
Addition	678	**Based on the insurance payment, we have adjusted our payment for the service to include only the co-pay and deductible.**
Addition	679	**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. A Certificate of Credible Coverage will be sent to you under a separate cover letter. Include this certificate with your re-billing to the carrier.**
	690, 691	**This claim has been re-entered/created by the Department of Community Health.** The explanation code is for informational purposes only.
	693-699	**The beneficiary's eligibility has been manually reviewed.** The explanation code is for informational purposes only.
	700	**The reimbursement amount was manually determined.** The explanation code is for information al purposes only.
	701	**A portion or all of the outlier days have been denied.** The claim has been adjusted accordingly.
	702	**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. The 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.
	703	**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.
	704	**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.** The explanation code is for informational purposes only.

Current Change	Code Number	Terminology
	705	**A computational error has been corrected and the total amount billed has been processed accordingly.** The explanation code is for informational purposes only.
	706	**For Inpatient Hospital: The beneficiary's beneficiary-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 refle ct the beneficiary -pay amount shown on the eligibility verification system for the month.
	707	**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. The exp lanation code is for informational purposes only.
	708	**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
	709	**A PACER number must be obtained before this claim can be paid.** Provider must obtain pacer number and enter it on the claim form.
	710	**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 f irst admission has been paid, then these services must be included on a claim adjustment for the first admission.
	711	**The Optical Character Reader could not read the typed print properly.** This may be corrected by cleaning the type font, changing the rib bon, or properly aligning the claim. The explanation code is for informational purposes only.
	712	**A review of this readmission appears to warrant two separate DRGs.** A claim for each admission must be submitted along with the required documentation atta ched to each claim.
	713	**The claim has been manually rejected.** A separate cover letter has been sent to the provider explaining the reason for this rejection.
	714	**The documentation is not adequate to warrant additional payment for this service.** If app ropriate, a claim adjustment should be submitted with complete documentation of the service provided. The explanation code is for informational purposes only.
	715	**Claims should be rebilled with the actual product cost of the item documented.** The explan ation code is for informational purposes only.
	716	**This claim was rejected in error and has been resubmitted by the Department of Community Health.** The explanation code is for informational purposes only.
	717	**The provider type code and/or provider ID Number were corrected. In the future, this information must be completed properly.** The explanation code is for informational purposes only.

Current Change	Code Number	Terminology
	718	**This claim has been corrected to correspond with information on the prior authorization form.** The explanatio n code is for informational purposes only.
	719	**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.** The explanation code is for informati onal purposes only.
	720	**The diagnosis code has been corrected to correspond with the diagnosis description.** The explanation code is for informational purposes only.
	721	**The Medicare status code has been corrected.** The explanation code is for informat ional purposes only.
Revision	722	**The date of service has been corrected to the proper eight (8) digit format.** The explanation code is for informational purposes only.
	723	**The frequency of this service exceeds Program parameters. Medical necessity must be documented.** The explanation code is for informational purposes only.
	724	**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 document ation supporting the Emergent Condition Code 1.
	725	**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.
	727	**This claim has been manually rejected for reasons specified by the accompanying explanation codes with "P" (pend) indicators.**
	728	**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.
	729	**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.
	730	**Mutually exclusive services have been billed separately and payment is not allowed.** These procedur es must be combined and rebilled on one claim line, using the appropriate procedure code.
	731	**Service not payable with other service rendered on the same date.** The service must not be rebilled.
	732	**This service is included in the reimbursement for the medical visit provided on the same date of service.** The service must not be rebilled.
	733	**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.
	734	**The quantity billed on this line is not consistent with the billing unit specified in Appendix F.** The claim should be billed with the correct qua ntity as specified in Appendix F.

Current Change	Code Number	Terminology
	735	**Multiple services are combined on one claim line.** Each service should be rebilled on a separate claim line.
	736	**This service is included in the surgical fee/delivery fee/antepartum fee.** The service must not be re billed.
	737	**Beneficiary ineligible for this service.** The service must not be rebilled.
	738	**This service is included as a component part of another service and cannot be reimbursed separately.** The service must not be rebilled.
	739	**The procedure code/procedure type code/drug code on this claim line should be rebilled with the correct code.** (The provider should also review the combination of procedure type code and place of service code.) The claim should be corrected and rebilled.
	740	**This service must be rebilled with a copy of the operative report, pathology report, or office or progress notes.** The claim should be rebilled with the appropriate documentation.
	741	**This payment reflects the maximum Medicaid allowance minus the other insurance payment indicated on the claim.** The explanation code is for informational purposes only.
	742	**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.
	743	**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.
	744	**Missing provider signature.** A signed claim should be rebilled.
	745	**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.
	746	**This service cannot be series billed.** Each date of service must be rebilled on separat e claim lines.
	748	**Services performed for the reported diagnosis code are not reimbursable due to the age or sex of the beneficiary.** The service must not be rebilled.
	749	**The pharmacy should recheck that the correct metric-billing unit as listed in the Michigan Medicaid Drug List (Appendix F) 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 wi th the appropriate documentation or corrected metric billing units.
	750	**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.

Current Change	Code Number	Terminology
	751	**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 ben eficiary -pay amount. Any services that are not covered by this amount may be rebilled.
	752	**Medicaid records show this beneficiary was deceased during this period.** The claim should be rebilled for services rendered prior to date the beneficiary expired.
	753	**Emergency condition not sufficiently documented.** Provider should supply more documentation and resubmit.
	754	**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: ➢ The service was billed incorrectly to Medicare, the provider should rebill Medicare. ➢ The service was not medically n ecessary, Medicaid will not reimburse for the service. ➢ 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.
	755	**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 sta tus code on each claim.
	756	**The payment information on the claim is inconsistent with the Medicare EOB.** The claim should be corrected and rebilled.
	757	**An invoice cannot be submitted to adjust a previous payment.** Proper claim adjustment procedures mu st be followed as specified in Chapter IV of the manual.
	758	**This claim adjustment or replacement cannot be processed because some or all of the information does not match the orginal claim.** A claim adjustment must match the last paid claim for the foll owing items: provider ID number, beneficiary ID number, Claim Reference Number, and claim line number. The claim adjustment should be corrected and rebilled. **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.
	759	**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 servic e 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.
	760	**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.

Current Change	Code Number	Terminology
	761	**The necessary documentation was not received.** The claim should be rebilled with appropriate, complete, legible documentation.
	762	**The submitted documentation was not adequate or not legible.** The claim should be rebilled with complete, legible documentation.
	763	**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. Chapter I contains information on the billing limitation.
	764	**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 act ivity 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.
	765	**The date of service is more than 12 months old.** The Department o f 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 Nu mbers of previous claim submissions for this service. Chapter I contains information of the billing limitation.
	766	**A claim adjustment to request additional monies for a service can be billed up to 12 months from the date of the original payment**. If the re has been no active review (as explained in Chapter I), the claim must **not** be rebilled.
	767	**If Medicare involvement prevented the claim from being billed to Medicaid within 12 months, refer to Chapter I for special billing instructions**.
	769	**Drug code for the service billed is listed in the drug code listing**.
	771	**The review of Medicaid records shows that this claim was previously paid.** The claim must **not** be rebilled.
	772	**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 reapply. **For Inpatient Hospital Charges Only:** The beneficiary is curre ntly enrolled in Medicare Part B only. The provider should refer to Chapter IV of the Hospital Manual for instructions to initiate Medicare Part A coverage. The provider is reminded to keep Medicaid claims active according to the policies in Chapter I o f the provider manuals.

Current Change	Code Number	Terminology
	773	**Medicaid reimbursement cannot be made for this service without further documentation from Medicare (e.g., Explanation of Benefits, voucher, written explanation).** The provider should rebill the claim and include the appropriat e documentation. **LONG-TERM CARE PROVIDERS:** The Explanation of Benefits is unacceptable documentation. **HOME HEALTH AGENCIES:** Medicaid reimbursement cannot be made for this service. Medicare will cover 100% of the cost or charge for home health services . There is no Part A or Part B deductible or coinsurance; therefore, the agency must not bill Medicaid for these services.
	774	**We have not received either an Informed Consent to Sterilization (MSA-1959) or Acknowledgment of Receipt of Hysterectomy Information (MSA-2218) form.** Please submit a completed form.
	775	The Informed Consent to Sterilization or Acknowledgment of Receipt of Hysterectomy Information form is invalid due to one or more of the following: ➢ required information is missing, ➢ information on the form does not match the claim, ➢ the form is not appropriate for the procedure, or ➢ 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 representativ e.
	776	**The diagnosis code indicated does not match the diagnosis file.** The provider should verify the diagnosis code used, correct, and rebill the claim.
	777	**Claim information is inconsistent with the submitted documentation or it is inconsistent with authorized services.** All data should be verified.
	778	**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 appropriat e, corrections should be made and the claim rebilled. If the data is correct, the service must not be rebilled.
	779	**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.
	780	**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 eligibi lity verification system. The claim should be corrected and rebilled.
	781	**The claim has 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.
	782	**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.
	783	**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.

Current Change	Code Number	Terminology
	784	**Multiple procedures or services have been billed on separate claims.** To be paid for this procedure or service, it is necessary to claim adjust the previously paid claim. A copy of the Remittance Advice page showing the paid claim must be sent with the claim adjustment.
	785	**Services billed exceed program limitations.** The service must not be rebilled.
	786	**Claim information is inconsistent with authorized services.** The service must not be rebilled.
	787	**Claim information for the beneficiary does not agree with submitted documentation or does not agree with authorized services**. 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.
	789	**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.
	790	**The required documentation regarding other insurance action is not complete.** The provider should refer to Chapter IV of the appropriate provider manual. The claim should be corrected and rebilled.
	792	**The beneficiary is not eligible and there is no pending application on file.** The service must not be rebilled.
	793	**The other insurance policy has master medical coverage.** The service must be billed to the other insurance carrier.
	795	**A manual review indicates these services are covered and benefits are currently available from another insurance carrier.**
	796	**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.
	797	**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.
	798	**These services cannot be billed under the mother's ID Number.** These services must be rebilled under the child's ID Number.
Addition	799	**(State Medical Program only) This claim was not prior authorized and the diagnosis does not support emergency coverage.**
	800	**The payment is for the quantity shown**. The explanation code is for informational purposes only.
	802	**Other insurance or Medicare money manually distributed.** The explanation code is for informational purposes only.
	803	**This provider type is not allowed for the beneficiary's age.** The claim must not be rebilled.
	804	**Services rendered to this county's State Medical Plan beneficiaries are the responsibility of the county.** Providers should contact the county FIA office for information regarding where to submit bills for these services.

Current Change	Code Number	Terminology
	805	**State Medical Program (SMP). Effective 11-01-1999 and after, payments for State Medical Plan (formerly General Assistance) services will be made by the Detroit Medical Center (DMC). Providers should continue to submit claims for services to State Medical 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.*
Addition	806	**The procedure code is inconsistent with the modifier used or a required modifier is missing.**
	809	**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.
	810	**The National Drug Code (NDC) billed has been terminated by the manufacturer.** If the wro ng NDC has been billed, you should rebill using the correct NDC.
	811	**The beneficiary is not in a long-term care setting and the unit dose system billed is not reimbursable.**
	813	**The quantity entry and package size for the National Drug Code (NDC) billed are inconsistent.** The pharmacy should check the quantity entry on the claim to make sure that decimals were billed for fractional package sizes (e.g., 18.1 gms) or that the quantity relates to the NDC package (e.g., billing 21, not 28, for an oral contra ceptive sold in packages of 21).
	814	**This National Drug Code (NDC) is being manually priced.**
Addition	817	**Outpatient hospital: Payment on this line is determined by group reimbursement policy. See section 6, procedure code/revenue code list.** The expla nation code is for informational purposes only.
	818	**Medicaid Health Plan (MHP) psychotropic claim with invalid NABP number.** Provider should verify correct NABP number and resubmit claim.
Addition	819	**Did not complete or enter accurately an appropriate HCPCS modifier.**
	821	**The product cost is paid based on the lower of charge or the AWP minus 15.1% for pharmacies owning five or more stores or for pharmacies with no retail customers serving long-term care beneficiaries.** The explanation code is for infor mational purposes only.
	822	**The product cost is paid based on the lower of charge or the AWP minus 13.5% for pharmacies owning one to four stores.** The explanation code is for informational purposes only.
	823	**The product cost is paid based on the lower of charge or manufacturer direct price.** The explanation code is for informational purposes only.
	824	**The product cost is paid based on the lower of charge or a Maximum Allowable Cost (MAC) price. The Michigan Medicaid Drug List contains the MAC prices. Payment for a drug entity will not exceed the MAC price unless prior authorization is approved.** The explanation code is for informational purposes only.

Current Change	Code Number	Terminology
	825	**The claim was paid based on the lower of charge or estimated retail price or retail Maximum Allowable Cost (MAC) price.** The explanation code is for informational purposes only.
Addition	827	**Claim/service lacks a valid COB code which is needed for adjudication.**
Addition	828	**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.**
Addition	829	**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.**
Addition	836	**Payment denied/reduced for absence of, or exceeded, pre-certification/authorization**.
Addition	837	**The disposition of this claim/service is pending further review.**
Addition	838	**The disposition of this claim/service is pending further review.**
Addition	839	**The procedure code is inconsistent with the modifier used or a required modifier is missing.**
	840	**The claim is reimbursed using the DRG policies.** The explanation code is for informational purposes only.
	842	**The services on this claim are reimbursed on a percent-of-charge basis.**
	843	**The services on this claim, for this DRG, are reimbursed on a percent-of-charge basis.** The explanation code is for informational purposes only.
	844	**The claim indicates a low-cost outlier.**
	845	**The alternative weight for the DRG reimbursement for this hospital was used in determining the reimbursement amount.** The explanation code is for informational purposes only.
	846	**The inpatient hospital claim is for a transfer beneficiary and is paid the daily DRG rate.** The explanation code is for informational purposes only.
	847	**The claim indicates a low-day outlier.** The claim is reimbursed at a percent - of-charge basis not to exceed the full DRG payment. The explanation code is for informatio nal purposes only.
	848	**The claim indicates a high-day outlier.** The explanation code is for informational purposes only.
	849	**The claim indicates a high-cost outlier.** The explanation code is for informational purposes only.
	850	**The beneficiary was readmitted within 15 days of a previous discharge.** Only the outlier payment is approved. The explanation code is for informational purposes only.
	854	**The Medicare coinsurance and deductible amounts for this DRG are being reviewed.**
	855	**The DRG assignment is being manually reviewed.**
	856	**This DRG requires prior authorization.**

Current Change	Code Number	Terminology
	857	**This DRG is being manually reviewed to determine the medical necessity and/or appropriateness of the admission.**
	858	**Individual consideration has been requested for reasons other than transfer or readmission.**
	859	**The wrong provider ID was used.** Provider should correct the provider ID and resubmit the claim.
	860	**The claim does not contain sufficient information for a reimbursement determination.**
	861	**The claim is reimbursed on a per diem basis.** The explanation code is for informational purposes only.
	862	**Medicaid's internal group number for the hospital has caused the claim to pend.**
	863	**The beneficiary was transferred to another facility/unit and the hospital has requested individual consideration for the full DRG payment.**
Addition	864	**Did not complete or enter accurately the CLIA number.**
Addition	865.	**The procedure code is inconsistent with the modifier used or a required modifier is missing**.
Addition	866	**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.** The explanation code is for informational purposes only.
	867	**This claim was rejected because the beneficiary was admitted and discharged on the same day and no accommodation day was billed.** The claim should not be rebilled unless there are both ancillary charges and accommodation day charges incurred.
	868	**The beneficiary was admitted and discharged on the same day and an accommodation day was billed.**
	869	**The Medicaid Health Plan rate cell could not be determined**.
	874	**The wrong Medicaid Health Plan ID number was used for the beneficiary's eligibility.**
	875	**Procedure code is not compatible with tooth number/letter.** If appropriate, the claim should be corrected and rebilled.
	876	**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.
Addition	877	**Pharmacy claims after July 2000 should be billed to PBM.**
Addition	878	**The modifier reported is not allowed for the procedure code and no explanation was supplied.**
Addition	879	**The disposition of this claim/service is pending further review.**
	880	**The total amount billed on this claim is $0.00.** The explanation code is for informational purposes only.
	881, 882	**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.

Current Change	Code Number	Terminology
	883	**The beneficiary is enrolled in a Medicaid Health Plan on the date of service but the hospital admission might be before the enrollment date.**
Addition	884	**The procedure code is inconsistent with the modifier used or a required modifier is missing.**
Addition	886	**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.**
Addition	887	**The National Association of Board of Pharmacies Number (NABP#) is NOT on the Department of Community Health Provider Enrollment file.**
Addition	888	**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.
Addition	890	**A modifier not appropriate for the procedure code has been reported and was not used to determine reimbursement.**
	891	**This claim is reimbursed at the operating per diem plus capital costs per case.** The explanation code is for informational purposes only.
Addit ion	892	**The wrong invoice document or electronic format was used.**
Addition	893	**Maternity case rate was paid.** The explanation code is for informational purposes only.
Addition	894	**Beneficiary not eligible for maternity case rate carve out.**
	895	**This claim is reimbursed under the standard rate DRG methodology**. The explanation code is for informational purposes only.
	896	**This claim is an additional page of a multipage claim. No reimbursement is to be made.** This explanation code is for informational p urposes only.
	897	**The claim is for Resident County Hospitalization services for a beneficiary not in Wayne County.**
	898	**The claim is pending for determination of Medicaid reimbursement after Medicare's payment.**
	899	**The claim is pending for determination of Medicaid reimbursement.**
	915	**Services in the inpatient hospital setting are not benefits of the State Medical Program.** The claim must not be rebilled.
	930	**This beneficiary is eligible for the Resident County Hospitalization Program as authorized by a county other than Wayne County.** The hospital used the provider ID Number for the Wayne County PLUS CARE Program. The hospital must rebill using the correct provider ID Number.

Current Change	Code Number	Terminology
	931	**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.
	932	**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.** The explanation code is for informational purposes only.
	933	**The physician's claim requires an authorization number for the admission.** This explanation code is for informational purposes only.
	934	**The date of admission is prior to the date of the admission authorization number.**
	935	**The admission date is more than 30 days after the date of the admission authorization number.**
	936	**The admission/readmission/transfer authorization number is missing.**
	937	**The admission/readmission/transfer authorization number is invalid.**
	938	**The admission/readmission/transfer authorization number on the claim was not assigned to this beneficiary.**
	939	**These UB92 hospital claims are temporarily being held for processing in a future payroll.**
	940	**The admission date on the claim does not match the from date.**
	942	**The secondary surgical procedure requires an admission authorization number.** The explanation code is for informational purposes only.
	943	**The secondary diagnosis requires an admission authorization number.** The explanation code is for informational purposes only.
	944	**The primary surgical procedure requires an admission authorization number.** The explanation code is for informational purposes only.
	945	**The primary diagnosis requires an admission authorization number.** The explanation code is for informational purposes only.
	946	**The elective admission requires an admission authorization number.** The explanation code is for informational purposes only.
	947	**A Patient Status Code of 30 (still a patient) was used on the inpatient hospital claim.**
Revision	948	**The outpatient claim indicates emergency room services (Procedure Code 169032 or Revenue Code 450) and subsequent admission to the inpatient hospital setting.**
	949	**Professional charges are not allowed on an inpatient claim.** Providers should refer to the billing chapter of the appropriat e provider manual for instructions for billing professional services. The inpatient charges should be rebilled on the inpatient hospital invoice.
	950	**This claim is being manually reviewed.**
	953	**The office copayment has been deducted for the State Medical Program beneficiaries.** The explanation code is for informational purposes only.

Current Change	Code Number	Terminology
	955	**The National Drug Code is missing or invalid.**
	956	**The product billed is not made by an allowable manufacturer.** The product must **not** be rebilled.
	959	**The extended stay authorization number for a psychiatric or rehabilitation admission does not match the period being billed.**
	960	**The authorization number does not match this psychiatric stay.**
	961	**The number of days authorized does not match the number of days billed for this psychiatric stay.**
	966	**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.
	967	**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.
	973	**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.
	975	**The provider has billed amounts (e.g., professional charges, Medicare charges, coinsurance/deductible) that are inconsistent for a Medicare coinsurance and deductible claim.**
	979	**Home health services were billed for a beneficiary who is in the nursing home, enrolled in a hospice program (Level of Care Code 16), or enrolled in Medicaid's Home & Community-Based Services Waiver for the Elderly & Disabled (Level of Care Code 22).** The claim must not be rebilled.
	980	**Medicaid reimbursement cannot be made for services rendered by this provider type.** The service must **not** be rebilled to Medicaid.
	981	**Medicaid reimbursement cannot be made to this provider type for this service.** The claim must **not** be rebilled to Medicaid.
	983	**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.
	984	**The procedure code requires documentation and documentation was not received with the claim.** The claim should be rebilled with appropriate documentation attached.
	990	**This claim requires documentation and documentation was not in the Remarks section of the claim or attached to the claim.**
Addition	991	**The procedure code/bill type is inconsistent with the place of service or incomplete/invalid place of service.**
Addition	992	**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.**
Addition	993	**This claim is being held for future processing.**