Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
4		7	The procedure code modifier listed on your claim is either invalid or the RBRVS payment rules do not allow this procedure to be billed with this modifier.
4		45	Modifier is invalid for the procedure code billed. Please correct and resubmit.
4		215	Services denied. The modifier billed is invalid for the procedure billed. Please correct and resubmit.
4		479	Services denied. The assistant surgeon modifier is invalid for the procedure code being billed. Please correct either the procedure code or the modifier and resubmit.
4		482	Services denied. The modifiers billed for this service are not billable together. Please correct and resubmit.
4		890	Claim/line denied. Monaural hearing aids must be billed with "RT" or "LT" modifiers.
4		896	Claim/line denied. Your claim does not indicate if the surgery performed was unilateral or bilateral. If the procedure was unilateral, please attach documentation of that to the claim and resubmit. If the procedure was bilateral, please attach a completed sterilization consent form or an explanation of medical necessity/emergency signed by the physician and resubmit.
4		953	Cardiac catheterization procedures performed in place of service "21" or "22", modifier "26" is required or a mental health procedure is being billed by a provider not authorized to bill the procedure.
6		63	The procedure you have billed is inconsistent with the recipient's age as listed on the Medicaid eligibility file or the recipient is not on the eligibility file. Check the procedure information provided on your claim for accuracy or verify recipient eligibility before contacting ACS for assistance.
6		143	Claim/line denied: revenue code is not valid for recipient's age.
6	N30	192	Services denied. Services are not covered for recipients over the age of 20 years.
6		217	Claim/line denied. Iv sedation is allowed only for individuals who are twenty years of age or younger and when one of the following procedures have been performed: 07230, 07420, 07241.
6		258	Claim denied. Services billed on this claim are not covered when billed by this provider for MHSP clients 18 years of age and over.
7		101	Procedure is inconsistent with recipient's sex.
7		144	Claim/line denied: revenue code is not valid for recipient's sex.
9		60	The diagnosis on your claim is inconsistent with the recipient's age as listed on the Medicaid eligibility file. Check the diagnosis information you have provided for accuracy before contacting ACS for assistance.
10		61	The diagnosis on your claim is inconsistent with the recipient's sex as listed on the Medicaid eligibility file. Check the diagnosis information provided on your claim for accuracy before contacting ACS for assistance.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
11		3	Line denied. The diagnosis coding is incomplete or does not explain the medical reason for the service. Refer to the current ICD-9-CM book, and correct and resubmit the claim. If you feel the claim was coded correctly and want it reviewed, the following information must be sent: 1. Completed CMS-1500, 2. Operative report, 3. Office notes, 4. TPL documentation, and 5. Medicaid remittance advice. Send to: physician services, P.O. Box 202951 Helena, MT 59620.
11		245	Service denied. This service is inconsistent with the diagnosis submitted on the claim.
13		54	The recipient file indicates a death date prior to the date of service.
15	N286	41	Services denied. The service you provided requires authorization by the recipient's primary care PASSPORT provider. The PASSPORT authorization number is missing or invalid. Please obtain authorization, correct and resubmit. Effective 8/1/03 if this is an emergency room service, place of service 23, the diagnosis code is not a pre-approved code or the procedure is not 99284 or 99285, the service is not considered an emergency.
15		150	Claim denied. The provider number on the claim and the prior authorization do not match. If possible, correct and resubmit. Otherwise, contact ACS for assistance.
15	N54	151	Services denied. The information on the claim does not match the information on the prior authorization record. Please verify the claim data against the prior authorization, correct and resubmit.
15	N54	204	Claim denied. The recipient ID number on the claim does not match the prior authorization. Verify the accuracy of the prior authorization number and recipient ID. Correct and resubmit.
15		861	Claim denied. Dates on state medical authorization do not cover dates of service on the claim.
16	MA61	15	Recipient number is missing. Complete missing information and resubmit the claim.
16	M119	21	Claim denied. The NDC is either missing or invalid. Resubmit with a valid national drug code.
16	M123	22	The metric quantity is either missing or invalid. Correct and resubmit the claim.
16	M123	23	The days supply is either missing or invalid. Correct and resubmit the claim.
16	M20	29	Procedure code is missing. Code with CPT-4 or HCPCS code and resubmit the claim.
16	M53	32	Accommodation days were omitted on the claim. Correct and resubmit.
16	N65	35	Field number 80 - 81e on the UB-92 contains a date but no corresponding surgical procedure code is present. Please complete the surgical procedure code and submit an adjustment to correct this paid claim.
16	N65	40	Line denied. Negotiated rate not on file.
16	N253	43	Claim denied. Attending physician's number is required.
16	M79	44	Services denied. The daily room rate is missing. Please correct and resubmit.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
16	MA66	46	A surgical procedure is present in field number 80-81e of the UB-92, and a corresponding date is required. Please complete the date and resubmit a completed adjustment form to correct this paid claim.
16	N37	77	Tooth number or quadrant indicator is missing or invalid. Please correct and resubmit.
16	N75	78	Tooth surface code is missing/invalid. Please correct and resubmit.
16	M119	102	Line denied for NDC not on file. Resubmit with valid national drug code.
16		139	Claim denied. The new/refill indicator is missing or invalid and/or the number of refills authorized is missing or invalid.
16		140	Claim/line denied: revenue code invalid-correct and resubmit with appropriate UB-92 revenue code.
16	M23	162	Claim denied. The ingredient cost is either missing or invalid.
16		167	Claim denied. This prescription was refilled too soon.
16		174	Claim/line denied. The copay, EPSDT or PASSPORT value is not 1 - 6. Please correct and resubmit.
16	MA66	188	Claim denied. A revenue code was present on the claim which requires a valid surgical (ICD-9-CM) procedure code be billed. Please correct and resubmit.
16	M20	193	Services denied. The vaccines administered were not indicated on the claim. Please add the procedures to the claim and resubmit.
16	M51	209	Claim/line denied. Miscellaneous DME procedure code billed and no description of the item was present. A description must be present for each miscellaneous code billed.
16	M54	210	Claim denied. Electronically submitted claim was transmitted without a net charge amount. Please correct and retransmit the claim electronically.
16	M51	227	Claim denied. The code billed is incorrect for the services provided. A more specific procedure code is available, and an unspecified or unlisted procedure code may no longer be used when billing for these services. Please correct and resubmit.
16	M123	234	The drug unit of measure (units qualifier or unit type) is missing or invalid (not UN, ML, GR or F2).
16	M79	270	The provider number on the one-day authorization span for the date of service matches the rendering provider number.
16	N57	271	The provider number on the one-day authorization span for the date of service does not match the rendering provider number.
16	N290	446	Rendering provider is required for the billing provider type and the rendering provider cannot be another group provider type.
16	N257	447	Healthcare providers must bill with a NPI.
16	N290	448	NPI is required for rendering healthcare providers.
16	N290	449	Provider type/specialty combinations which are not required to submit a rendering provider cannot submit a rendering which is different than the billing provider.
16	MA30	523	The bill type frequency of 4 or 5 is invalid. The provider must submit an adjustment to the original claim with the corrected charges.
16	MA30	524	The bill type frequency billed is a 2 or 3 and the Medicaid covered days is less than or equal to 30 days.
16		526	The cost-to-charge ratio is missing from the provider record. The claim will price once the provider record is updated.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
16	N65	805	Line denied. An ancillary revenue code requires an accompanying surgical procedure code and date. Please complete the surgical procedure code with the date and resubmit an adjustment form to correct this paid claim.
16		820	Refill indicator must be either a "Y" or blank. Please correct the refill indicator and resubmit.
16	MA64	827	This claim was denied because the patient has more than one insurance and only one EOB was attached. Please rebill the claim to all insurances.
16	MA130	828	Claim/line denied. Information on the claim form is not legible.
16	M119	844	This drug, dermal tissue, or blood product requires manual pricing by the physician services program. If the product has an NDC (national drug code), send in a copy of the claim and indicate the NDC and total amount given in field 19 of the CMS-1500 claim form. If product does not have an NDC, send in a copy of the claim along with an invoice. Please send to: Physician-Related Services, P.O. Box 202951, Helena, MT 59620-2951.
16	MA122	905	Claim/line denied. A line level date of service on this claim is invalid. Please correct and resubmit.
16	N187	951	This procedure requires manual review. If this is an unlisted procedure code, make sure another code is not available. This procedure requires notes to substantiate medical necessity. Please send a copy of the claim and notes to: Medicaid Services Bureau, P.O. Box 202951, Helena, MT 59620.
18		1	This claim or line is being denied as a duplicate. You have already billed and been reimbursed for this service. Please check your records or statements of remittance for the prior payment.
18	N75	94	Claim/line denied. More than one surface restoration code has been billed for the same tooth on the same day. Please correct the claim by coding for the total surfaces restored on the same day and resubmit.
22	MA04	4	Based on the information you presented on your claim, the recipient appears to have other insurance coverage. Please indicate on the claim the amount paid by the other insurance or attach an insurance denial letter and resubmit the claim. If the patient doesn't have other insurance coverage, please remove the TPL information from the claim form and resubmit.
22	MA04	25	This claim has been denied for one or both of the following reasons: 1) the number of units appears to be excessive, or 2) the pricing and/or quantity indicates that an incorrect NDC may have been used. If you feel this is incorrect, contact Betty Devaney at 444-3457.
22	MA04	36	Claim denied. The Medicare paid date is not present on the EOB or spread sheet received. Please resubmit with a complete copy of the Medicare EOB or spread sheet which includes the Medicare paid date.
22	MA04	47	Claim/line denied. Please resubmit the claim form with a copy of the Medicare explanation of benefits attached.
22	MA04	56	Our records indicate the recipient has Medicare coverage. Please submit the claim to Medicare for payment or resubmit the claim to Medicaid with either the Medicare information in form locators 39, 40, and 54 or a Medicare EOMB attached.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
22	MA04	90	Claim denied. This recipient has third party insurance. Submit the claim directly to Montana Medicaid with documentation from the private insurance. Please refer to the claim denial above for details on the other insurance.
22	N192	235	Line denied. Medicare did not pay on this service. Therefore, no QMB program benefits are available.
22	N30	257	The client is participating in the Program for All-Inclusive Care for the Elderly (PACE) and no other benefit is available.
22	MA04	261	Claim/line denied. Our records indicate client has Medicare coverage. Please submit the claim to Medicare for payment or resubmit the claim to Medicaid with the Medicare EOB attached.
22		555	Claim denied. This recipient has CHIP coverage and the services may be mental health services covered by the CHIP carrier. If the CHIP carrier has denied for exhausting benefits limits or the service is not a benefit of the contract, resubmit the claim with the denial attached.
22	N8	706	Medicare has denied this claim indicating that another payer or another Medicare carrier is the primary payer for this service. Please seek payment through the correct primary payer.
22	N8	841	Medicare or another insurance denied this service because a different third party payer is primarily responsible for payment. Please bill other insurance and then bill Medicare if applicable before resubmitting to Medicaid.
23		701	Medicare has denied this claim as a duplicate service. If your claim has not already been processed by Medicaid for the Medicare balance, please submit a completed claim form with a copy of the Medicare EOB attached.
23		840	Based on the information provided on the Medicare EOB, no Medicaid payment is available on this service. If you have a question about this denial, please contact the Provider Relations Department for assistance.
23		893	Information attached to your claim indicates the patient/family received payment from the insurance company but no credit was reported on the claim. Please resubmit the claim with the insurance payment amount indicated on the claim.
23	N31	997	The third party resources or Medicare payment exceeds the Medicaid allowed amount for this claim. Therefore, this claim has been processed with a zero ($0.00) paid amount.
24		251	Provider cannot bill "fee for service" claims.
24		301	Services denied. MHSP adults cannot be billed as fee-for-service or your provider type cannot bill for MHSP adult services.
24		430	Claim denied. Recipient is in an HMO and the service is an HMO covered service. Please submit the bill to the HMO.
24		433	Claim denied for one of the following reasons: 1) the recipient is not covered by this HMO or 2) HMOs cannot submit claims for capitation payments.
29		8	Service denied. Claim was billed more than 365 days past the date of service and no documentation of retroactive eligibility determination was attached. If the recipient indicates legibility may be retroactive, contact the county office for a copy of the FA-455.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
29		58	Dates of service more than two years old. The age of this claim precludes the system's ability to accurately verify eligibility. Please check the dates of service on the claim for accuracy prior to contacting ACS for assistance.
29		708	This is a Medicare crossover claim that has been denied by Medicare because the time limit for filing the claim has expired.
30		233	Service denied. Verify procedure code or type of service. As billed this is either a non-covered service, the procedure code has been deleted or another code should be used according to the RBRVS status code (for CMS-1500 billers) or the APC status code (for outpatient hospital billers) or your current Montana Medicaid provider manual.
31		14	Claim denied. Recipient ID number is invalid. Please reference the ID card, correct and resubmit the claim.
31		48	Claim denied. We have no Medicaid eligibility on file for this patient for the dates of service on the claim. Check the dates of service and refer to the ID card or the patient for correct eligibility information before resubmitting. If you have documentation of eligibility or a one-day authorization, you will need to contact the client's county office of human services (welfare office) to have the problem resolved.
31	MA61	50	The recipient number billed is not on file in the system. Refer to the ID card or the patient for the correct number and eligibility information before resubmitting.
31	N245	129	We were unable to convert the Medicare recipient number on this crossover claim to a valid Medicaid recipient number. Please resubmit these charges on a paper claim with valid Medicaid values and a copy of the Medicare EOB attached. Also, if you see this patient frequently, please contact the local office of human services to have the patient's Medicare number corrected on the Medicaid file.
31		212	Services denied. The provider is a CHIP only provider and the recipient is not a CHIP client.
31	MA36	232	Recipient name is missing. Complete missing information and resubmit the claim.
31		486	Services denied. Unable to establish recipient eligibility for these services.
31		707	This is a Medicare crossover claim that has been denied by Medicare because the service spans are outside the individual's eligibility span.
31	N192	885	Services denied. No QMB eligibility is on file for this patient for the dates of service.
38		132	Claim/line denied. Recipient not authorized to receive services from this provider.
38		171	Claim denied. The provider billing this service is not a member of the payee provider's group.
38		196	Services denied. The recipient is a participant in the MHSP and you have not returned to ACS a completed provider enrollment addendum. Please contact Provider Relations for assistance.
38		437	Claim denied. This provider is not on this plan of benefits.
38		476	Services denied, recipient is locked-in to a different provider.
38		895	Claim/line denied. Client is not authorized to receive services from this provider.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
39		152	Service denied. The prior authorization request for these services was denied.
40	N59	280	Services denied. A non-emergency service was performed in an emergency room setting.
40		443	Claim denied. An invalid combination of emergency revenue codes has been billed. Please refer to the UB-92 manual for instructions concerning the proper combination of emergency revenue codes.
40		830	The services billed are emergency room related services. This recipient is restricted and the services are not for a bona-fide emergency.
40		913	Claim/line denied. The emergency (emg) indicator field is invalid. Please correct and resubmit.
42		121	Claim/line denied. Charges for frame repair cannot exceed the allowed charge for new frames.
42	M86	154	Claim/line denied: only one specimen collection fee allowed per date of service.
42		166	Claims denied. The cost of this prescription exceeds the maximum allowed.
42		172	Services denied. The DRG reimbursement amount exceeds the submitted charges by more than the prescribed limit. Please verify diagnostic and procedure code information and correct if necessary. If correct, please contact: Hospital Services Program Officer, DPHHS, P.O. Box 202951, Helena, MT 59620.
42	M7	182	Services denied. The purchase price limit has been reached or exceeded for this capped rental item. For assistance please contact Provider Relations at 1-406-442-1837.
42	M86	191	Services denied. Provider cannot bill for more units of service than the number of days in the span of dates billed. Only one unit of service can be billed per day for this procedure. Please verify dates of service and units, correct and resubmit.
45	M75	378	This line bundled to a lab panel or ATP code. Refer to the appropriate edition of CPT-4 for further information on lab panel codes.
45		804	The amount billed in total charges is not your daily rate times the number of days. Correct the total and net charges and resubmit the claim.
50		240	ClaimsGuard detected a laboratory service billed that is not appropriate for the diagnosis billed.
50		704	Medicare has denied this claim as not medically necessary. Medicaid coverage is limited to "medically necessary" services as well. The determination may be appealed through Medicare.
50		867	Denied. Claim does not meet the criteria for medical necessity.
54		705	Medicaid does not cover surgical assistant services for this procedure. Medicaid is following the Medicare list of surgery procedures for which an assistant is not medically necessary. Since the service is not medically necessary, you may not bill the patient for this charge.
56		87	Less than effective drugs are non-covered.
58	M77	82	The place of service code billed is not valid for the procedure code billed. Please verify the accuracy of the place of service and procedure codes prior to contacting ACS for assistance.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
58	M77	84	Claim/line denied. The place of service is missing or invalid. Refer to the Medicaid instructions for completing the CMS-1500 (12/90) claim form handbook, correct and resubmit.
58		211	Services denied. Services for recipients over twenty-one years of age and under sixty-five years of age are not covered in an IMD (snf/mental health aged) facility.
B15	M80	5	This service may be included in another service or subsequent procedures were not billed with the appropriate modifier.
62		76	Claim/line denied. Procedure requires prior authorization.
62		917	Claim personal resource amount does not match the client's personal resource amount for providers that are swing bed, nursing home, SNF or ICF.
96		28	No payment due. Non-covered charge exceeds or is equal to the covered charge.
96		33	Line denied. Non-covered controlled substance.
96	MA66	62	Service denied. Verify procedure code or type of service. As billed this is either a non-covered service, the procedure code has been deleted or another code should be used according to the RBRVS status code or your current Montana Medicaid provider manual.
96		98	Claim/line denied. This product is not a benefit of Medicaid.
96		114	Claim denied due to termination of the state medical program.
96		141	Claim/line denied: this revenue code is for a non-covered service.
96	N30	161	Claim/line denied. "SLIMB" clients are not eligible for medical services. Only the part b Medicare premiums for this patient are paid by Medicaid.
96		178	Services denied. The procedure billed is not a benefit of Montana Medicaid. Please review the allowed tooth numbers in the dental services manual for full coverage crown restoration.
96	MA101	213	Over the counter antacids and laxatives are not covered for nursing home patients. These over the counter products are included in the nursing home routine rate (per diem) paid by Medicaid. Therefore, this item is the responsibility of either the nursing home or the patient.
96	N192	276	Service denied. This recipient has QMB only eligibility for the dates of service billed.
96		854	TAD denied. Provider indicated the billing was not valid.
96		869	Denied. Eyeglasses, dentures & hearing aids are not covered for patients 21 years old or older unless a form SRS-EA-150 (certification of irreparable injury) which has been completed, signed, and dated by the appropriate professional is attached to the claim.
96		892	Claim denied. Cardiac rehabilitation exercise programs and other outpatient programs primarily educational in nature are not a benefit of the Medicaid program.
96		897	Claim denied as directed by provider. Billed charges invalid for service billed.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
97	M144	186	Service denied. This surgical, medical or evaluation and management (E&M) procedure is included within the established global period of another surgical or medical procedure, or the E&M procedure included in the global period has already been paid. If you feel this denial was inappropriate, please resubmit and/or adjust the affected claim(s) with the appropriate modifier(s).
97		187	Line denied. Two hearing aid dispensing fees have been billed for this patient for the same service. If binaural hearing aids were dispensed, please submit an adjustment to correct this paid claim to one dispensing fee charge under the correct code for binaural aids.
97		199	Services denied. This service has been previously paid with another procedure code for the same service.
97	M144	239	Service denied. This evaluation and management service (E&M) is included within another surgical or medical procedure on the same day. If you feel this denial was inappropriate, please resubmit and/or adjust the affected claim with the appropriate modifier for the E&M code.
97		291	Claim/line denied. More than one unit of service billed for a global delivery service procedure code.
97	M15	484	Claim/line denied. This supply code cannot be billed in conjunction with the RBRVS procedure on the claim.
107	N192	123	Line denied. Medicare did not pay on this service. Therefore, no QMB program benefits are available.
107	N122	243	Add-on codes cannot be billed without a related or qualifying service being previously paid or present on the claim.
107		246	Service denied. Observation services are allowed only with certain diagnoses, and with the required supporting services on the same claim. If you feel this denial was inappropriate, please resubmit and/or adjust the affected claim with the appropriate diagnosis or procedure code.
107	M50	442	Claim denied. Revenue code 452 has been billed by itself or in an invalid combination with another emergency revenue code. Revenue code 452 can be billed only with revenue code 451. Please refer to the UB-92 manual for additional instructions.
107		802	Claim denied. The attachment from the third party payer did not indicate the reason for denial, or the message/remark/reason code text was not included. Therefore, Medicaid is unable to consider this claim for payment.
107		823	This claim has been reviewed and denied by the third party unit. We were either unable to match the insurance EOB to your claim or unable to determine the amount of third party payment from the EOB.
108		175	Claim/line denied. Multiple units of service have been billed on a rental procedure. Please correct the claim to one unit of service per month and resubmit.
108		181	Services denied. The unit limit has been reached for this capped rental item.
109		431	Claim denied. This recipient is covered by the MHAP. Please contact Montana community partners toll free at 1-888-599-2233 for assistance with this claim.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
110		10	Claim denied. One of the following conditions concerning the signature date existed on the claim: 1) missing or invalid; 2) dated after received at ACS (this date cannot be in the future or 3) prior to the last date of service.
110		13	Services cannot be billed prior to date performed.
110		157	Claim denied. The bill date on your electronic claim is prior to the date of service. Correct the bill date and resubmit the claim on your next electronic submission.
16	M123	149	Claim denied. The compound code is either missing or invalid.
119		37	Claim/line denied. Hearing aid battery purchase limited to three (3) packages in any one calendar month.
119		49	Claim/line denied. A maximum of three fifteen (15) minute personal care services may be billed per line.
119		53	Claim denied. The number of days supplied and units dispensed exceed the maximum allowed by Medicaid.
119		91	Claim/line denied. Hearing aid battery purchase is limited to eight (8) cells per recipient per calendar month.
119		105	Claim/line denied. Physical therapy visits are limited to 100 per fiscal year per recipient.
119		106	Claim/line denied. Speech therapy services limited to 70 hours per state fiscal year for a recipient.
119		107	Claim/line denied. Speech therapy services limited to 100 hours per state fiscal year for a recipient.
119		108	Claim/line denied. Home health visits with procedure codes 00051, 00052, 00053, and 00055 are limited to 200 per state fiscal year/recipient.
119		109	Claim or line denied. Charges exceed the home health limit of $400 per month, per recipient.
119		110	Claim/line denied. Combined mental health services have exceeded the 22 hour per fiscal year limit.
119		111	Claim/line denied. Fluoride treatment is limited to one treatment every six months for adults.
119		112	Claim/line denied. Full mouth x-rays are limited to one series every three years for adults.
119		115	Claim/line denied. Dental prophylaxis is limited to one treatment every six months for adults.
119	M90	116	Claim/line denied. Eye exams are limited to one per calendar year.
119		117	Claim/line denied. Visual training sessions limited to two one-hour sessions per week.
119		118	Claim/line denied. Visual training sessions limited to 24 per year.
119		119	Claim/line denied. Glasses limited to one in 12 months for recipients under twenty-one (21) years for age.
119		120	Claim/line denied. Combined mental health consultation and testing services have exceeded the 12 hour per fiscal year limit.
119		122	Claim/line denied. Respite care limited to 25 days per fiscal year.
119	N59	124	Claim/line denied. Bite wing x-rays are limited to four films per twelve month period. This individual reaches this limit on a prior dental visit.
119	M90	125	Claim/line denied. Periodic dental exams are limited to one exam per 365 days for adults.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
119		126	Claim/line denied. Social worker consultation services have exceeded the 6 hour per fiscal year limit.
119		133	Claim/line denied: Dietician services limited to 12 hours per fiscal year.
119		134	Claim/line denied. Respiratory services limited to 24 hours per fiscal year.
119		135	Claim/line denied. HCBS psychological consultation limited to 6 hours per fiscal year.
119		136	Claim/line denied. Respite care limited to 25 days per fiscal year.
119		177	Benefit limits for this time period have been reached. Please refer to your program manual for details.
119		179	Periodic orthodontia visits are limited to once every 27 days. Please review the date of the last periodic visit and, if necessary, resubmit.
119		180	Claim/line denied. The maximum number of units allowed for this item has been paid.
119		183	Services denied. The limit of seventy hours of physical therapy per fiscal year has been reached. If additional therapy is required, contact the therapy program officer at DPHHS, Health Policy and Services Division, P.O. Box 202951, Helena, MT 59620.
119		184	Services denied. The limit of seventy hours of occupational therapy per fiscal year has been reached. If additional therapy is required, contact the therapy program officer at DPHHS, Health Policy and Services Division, P.O. Box 202951, Helena, MT 59620.
119		185	Services denied. The limit of seventy hours of speech therapy has been reached. If additional therapy is required, contact the therapy program officer at DPHHS, Health Policy and Services Division, P.O. Box 202951, Helena, MT 59620.
119		194	Services denied. The limit for respite services provided by a mental health center has been exceeded.
119		197	Services denied. The maximum allowed units for care coordination case management has been exceeded.
119		198	Services denied. The number of services allowed for therapeutic home visits in a fiscal year has been exceeded.
119		200	Claim/line denied. More than 200 diapers have been provided to this recipient in a one month period.
119		218	Services denied. Visual examinations are limited to one every two years.
119		219	Payment reduced or paid at zero. Chip dental reimburses at 85% of billed charges and payment limit is $350 per enrollee per plan year (October - September). Enrollee may be billed for the balance.
119		220	Services denied. Another frame for this CHIP client has been paid within one year.
119		221	Services denied. Two lenses have already been paid for this client within one year.
119		222	Claim line denied. Another frame or dispensing service for this client has been paid within two years.
119		224	Services denied. You have billed more than one full debridement within a 365 day period.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
119		225	Services denied because you have billed more than one unit of periodontal maintenance in a 90 day period.
119		226	Services denied. Only one crown is allowed per tooth every five years.
119		228	Two dispensing services for single vision eyeglasses for this client have been paid within two years.
119		231	More than one unit of 90801 billed in three days or more than 12 units of H2011 billed in three days (an episode of care) for a mental health crisis stabilization client.
119		237	Services denied. The unit limit has been reached for this capped rental item.
119		241	Claim/line denied. Home health skilled nursing visits (procedure code 00050) limited to 365 per state fiscal year/recipient.
119		281	More than 32 hours of H2019 have been billed in a month for a MHSP client.
119		282	More than 24 units in combination for procedure codes 90804 - 90807, 90846 - 90899 in any combination have been billed for a MHSP client in a State Fiscal Year.
119		333	Claim denied. Two lenses have already been paid for this client within a year.
119		455	Claim/line denied. This patient has exceeded 12 (twelve) home health aide visits in one state fiscal year.
119		460	Claim/line denied. Occupational therapy services are limited to 100 hours per state fiscal year per recipient.
119	M53	483	Services denied. The units billed exceed the maximum units allowed for this procedure. Please correct and resubmit. If you believe this was denied in error, please send a copy of the claim, the statement of remittance showing the denial, and medical notes documenting services provided to: DPHHS, Health Policy and Services Division, P.O. Box 202951, Helena, MT 59620
119		800	Claim/line denied. Glasses limited to one in two years for recipients 21 years and older.
119	N10	852	Claim has been reviewed and denied by state consultant.
125	N52	2	Claim denied. There is more than one managed care span in the system. For assistance contact ACS.
125	M52	11	Date of service is missing/invalid. Please resubmit the claim form with a correct date of service.
125	MA06	12	Line denied. The ending date of service in the span shows a date which is prior to the beginning date of service in the span. Please resubmit your claim with corrected dates of service.
125	M50	16	Revenue code missing. Reference the UB-92 manual, code with appropriate revenue code and resubmit the claim.
125	MA43	26	Patient status on claim is invalid. Please correct and resubmit.
125	M53	27	The line item charge is missing or zero. Correct and resubmit the claim, unless this is a "no charge" item or service.
125	MA40	30	The admission date is later than the from date. Correct and resubmit the claim.
125	N10	31	Reviewed and denied by designated review organization.
125	MA40	34	Services denied. The admission date is missing. Please correct and resubmit.
125	N62	59	Rebill on separate claims before and after your fiscal year end date.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
125	N28	97	Claim denied. The patient's signature and date on the consent form must be at least 30 days before the date the sterilization was performed. Please refer to the family planning section of your provider manual for specific instructions.
125	M54	137	Claim denied. The total amount charged is either missing or invalid.
125	M50	146	Line denied. This revenue code is invalid for the type of bill present on your claim. Please correct and resubmit the claim. (if this is a laboratory charge on an outpatient claim, itemize the laboratory services and resubmit with CPT procedure codes in addition to the revenue code).
125	M50	147	Claim/line denied: revenue code invalid or not assigned.
125	MA30	148	Claim denied. UB-92 is invalid claim type for these services.
125	N34	160	Provider cannot bill for services on a CMS-1500 claim form. Resubmit on a UB-92.
125	MA82	176	Claim denied. Due to an error in the dates of service the payee provider number cannot be verified by the system. Please correct the dates and resubmit.
125	M57	189	Service denied. Provider number is not present on the claim.
125	N47	202	This patient appears to have been transferred from one facility to another. Please verify the source code and patient status code. Correct and resubmit.
125	MA30	242	Service denied. Code G0244 appears on the claim and the bill type is not 13x.
125	MA63	249	Service denied. E diagnosis codes cannot be used as primary diagnosis codes.
125	N65	250	This line was denied because the outpatient code editor is unable to price this APC service. Please submit an adjustment with the appropriate type of bill and revenue/procedure code combination.
125		275	Claim denied for one of the following conditions: missing or invalid group number or missing or invalid eligibility override.
125	MA42	278	Admit source missing/invalid.
125	MA41	279	Admit type missing/invalid.
125	M54	300	Claim denied. The total charges field on this electronic claim did not contain an amount. Please correct the problem and resubmit the claim.
125	M134	409	Service denied. Either the billing provider has a financial interest in the referring provider or the referring provider has a financial interest in the billing provider.
125	N34	690	Claim denied. Please resubmit on correct claim form.
125	N48	821	The insurance or Medicare documentation attached is invalid/incomplete.
125	MA06	831	Claim/line denied. Date of service incomplete, correct and resubmit in month, day, year format.
125	N34	835	Claim denied. Swing bed facilities cannot bill on a MA-3 claim form.
125	N39	837	Service denied. The procedure billed is not a benefit for the tooth number of surface number billed. This service should be billed under the appropriate restoration procedure code. Please correct and resubmit.
125	MA81	850	The signature on your claim form is missing. Please correct and resubmit.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
125	M53	873	Claim/line denied. The procedure code that you have billed is for one complete eye examination. This code should only be billed with one (1) unit of service in field 24f. Please correct the claim and resubmit.
125	M54	891	Line denied. Bill usual and customary charges on each line. Do not bill Medicare allowed, TPL allowed, co-insurance or deductible amounts as Medicaid billed amounts.
125		899	The claim form you have submitted cannot be processed successfully because it contains too many lines. Please submit a separate, complete CMS-1500 for each six services or charges.
125		909	Claim/line denied. The PASSPORT override indicator is invalid. Please correct and resubmit.
129	MA04	660	This claim has been reviewed and denied. We were unable to resolve a conflict in the amount of coinsurance or deductible reported to us on the Medicare tape. Please resubmit the claim on paper with a copy of the Medicare EOB attached.
129	N48	829	Claim or line denied. The services shown on the Medicare explanation of benefits and/or the insurance EOB do not correspond with the services on the claim form.
129	MA04	838	The Medicare EOB or insurance statement which was attached to your claim was incomplete or illegible. Please resubmit your claim with a complete, legible copy of the insurance statement or Medicare EOB.
129	N8	839	Claim/line denied. The Medicare EOB. which was attached to your claim did not clearly specify the reason that Medicare did not make a payment. Please attach an explanation for the Medicare denial to the claim and resubmit with the EOMB for reconsideration.
129	N48	872	Claim/line denied. The service billed does not appear on the Medicare or insurance explanation of benefits attached to the claim.
129	N8	876	Claim/line denied. Medicare/and or other insurance has denied this service for lack of information or invalid information. Please respond to Medicare's/and or the insurance company's request for additional information prior to billing Medicaid.
129	MA92	898	Claim denied. Our records indicate this recipient does not have insurance coverage with the company from which an EOB was obtained.
129	MA92	903	This claim was received and reviewed by the TPL unit. No documentation was attached to allow claim to be considered for payment. Please provide either the amount paid by the other carrier or attach appropriate documentation for review.
133	N154	190	Claim pended for thirty days. Please submit a correct address to Provider Relations at ACS, P.O. Box 4936, Helena, MT 59604 before the thirty day grace period expires or your claim will be denied.
133		900	This claim is currently in process within our system.
133		901	Claim suspended pending receipt of recipient eligibility information.
133	N31	911	Claim suspended for thirty days pending license information. Please send a copy of your current license to ACS, P.O. Box 8000, Helena, MT 59601 or fax to 1-406-442-4402. Claims will be denied if license is not received within thirty days.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
135	MA43	203	Claim denied. Patient status, form locator #22 is "30". Hospitals being reimbursed using the prospective payment (DRG) methodology may not interim bill.
136	N8	702	Medicare denied this claim because of a need for additional information. Medicaid cannot consider the claim for secondary payment until Medicare has processed a claim with complete information. Please refer to the Medicare EOB for details and follow up with Medicare.
136	N36	703	Medicare has denied this claim because it was billed incorrectly. Medicaid cannot consider the claim for secondary payment until it has been resolved with Medicare. Please resolve the claim with Medicare and resubmit.
136		709	This is a Medicare crossover claim that has been denied by Medicare because the procedure, modifier, or diagnosis is inconsistent with the situation billed.
136	N8	833	Claim/line denied. Medicare or the insurance carrier has denied as a duplicate. Please resubmit with original Medicare or insurance EOB.
136	MA04	914	Medicaid does not pay for this service unless allowed by Medicare.
140		856	Claim denied. Recipient name and ID mismatch. Please correct and resubmit.
141		38	Dates of service are not within recipient's nursing home span.
141		51	The patient is ineligible for a portion of the days billed. Please verify the recipient's eligibility and rebill only for the covered days.
141		55	The recipient is ineligible for a portion of the services. Resubmit with the services itemized by date.
141	N74	223	Services denied. The type of eligibility, MHSP, CHIP or Medicaid, is unclear because the dates of service on the claim are for more than one month and the recipient has different eligibility for each month. Please submit a separate claim for each month of service.
141		806	Recipient ineligible for a portion of the claim. Co-insurance\deductible reduced.
150		17	Level of care indicator is missing/invalid. Correct and resubmit the claim.
150	N113	244	ClaimsGuard detected a new visit E&M billed but patient has been seen by this provider within three years.
151	M86	214	Claim/line denied. Only one scheduled hospital dental treatment is allowed for a provider on the same day.
151	M86	216	Claim/line denied. More than the maximum allowed of two units were billed for this procedure.
167		24	Diagnosis code is missing. Code with appropriate ICD-9-CM diagnosis code and resubmit.
167		70	Services denied. One of the following conditions exits related to the diagnosis code billed: the diagnosis code is not covered by Montana Medicaid, is invalid or may require additional digits. Please refer to your current ICD-9-CM code book. Contact ACS Provider Relations department for coverage by Montana Medicaid.
167		71	Diagnosis code invalid/incomplete. Correct with ICD-9-CM-CM diagnosis code and resubmit.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
170		65	Services denied. This provider type is not allowed to perform this procedure.
170		83	Provider specialty not allowed to perform this procedure.
170	N95	145	Line denied. This revenue code cannot be paid to this provider type. Please verify the accuracy of revenue code, provider number, and claim form used in billing. Resubmit on the correct claim form with the correct Montana Medicaid provider number.
170		156	Claim/line denied. Mid-level practitioner providers may not bill for services with this procedure modifier.
171	M49	304	Claim/line denied. Dialysis services were either billed with the hospital provider number (adjust to change the provider number to the dialysis number) or the value code 68 was not present on the claim in field locators 39, 40 or 41.
173		127	Claim denied. Prescribing physician number invalid.
175		163	Claim denied. The prescription denial override code is either missing or invalid.
175		272	Claim denied. Dispensed as written (brand needed) indicator is either missing or invalid.
175		273	Claim denied. The date the prescription was written is either missing or invalid.
175		302	Claim denied. The prescribing physician field is either blank or invalid. Please review and resubmit the claim with a valid DEA number.
176		165	Claim denied. This drug has been discontinued.
177	N30	72	Claim denied. This individual's eligibility is not approved for this service. Please contact your eligibility technician for information regarding patient's deprivation code.
177		255	A provider type other than a PRTF provider has billed for services for a client residing in a PRTF.
177		256	A PRTF has billed services for a client that does not have a PRTF managed care span on file.
177		259	Claim denied due to no Part B eligibility for professional or outpatient crossover claim and the client is QMB, SLMB, QI or Part B buy-in and no Part B eligibility on file
177	N30	260	Claim denied due to no Part A eligibility for inpatient crossover claim or client is QMB, SLMB, QI or Part A buy-in and no Part A on file.
181		64	Denied. This procedure code is not covered on the date of service billed. Please verify that a current procedure manual is being utilized for coding the services billed.
181	M51	80	The type of service or procedure code is invalid. Refer to your provider manuals for details on valid procedure codes for your area of service. For CMS-1500 billers, please complete field 24c with a valid type of service code and complete field 24d with a valid procedure code.
181		85	For medical claims: there is no Medicaid fee on file for this date of service, or the procedure/type of service is not covered on the date of service. For pharmacy claims: the drug code is not covered on the date of service. For dental claims: the procedure billed is invalid. Please refer to your current Medicaid provider manual for proper coding.
181	MA66	385	Claim denied. The primary surgical procedure (ICD-9-CM-CM) code is invalid. Please correct and resubmit.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
181	M67	386	Claim denied. One of the secondary surgical (ICD-9-CM-CM) procedure codes is invalid. Please correct and resubmit.
181		879	Claim denied. The surgical procedure code is invalid. Please code with an ICD-9-CM procedure code (field 80 to 81 of the UB-92 form) and resubmit the claim.
182		377	Service denied. Modifier is not allowed for the date of service or the modifiers cannot be billed together.
182		480	Services denied. The modifier being billed in not on file.
183		19	Prescribing provider number is missing or invalid. Correct and resubmit the claim.
183		468	Claim denied. Prescribing physician must be a valid DEA number.
183	M33	469	Reserved. No current message.
184	N286	477	Service denied. The PASSPORT number on the claim is not on the provider master file. Please correct and resubmit.
184		478	Service denied. The PASSPORT number on the claim is invalid for the dates of service. Please contact the PASSPORT provider for the correct number for these dates of service, correct the claim and resubmit.
185		20	Prescription number is either missing or invalid. Correct and resubmit the claim.
185		88	Provider eligibility has been denied per state request.
185		470	Claim denied. These services must be billed as a Rural Health Clinic service on a UB-04.
185		819	This recipient is on restriction to another provider. This service is not payable.
197		9	Service denied. The prior authorization request for these services is pending. For assistance contact the approving agency.
197		57	Claim denied. State medical inpatient claims and certain outpatient surgical procedures require certification from "Managed Care Montana". Please attach the certification letter to the claim and resubmit it for processing. If you have no certification letter for this service, contact "Managed Care Montana" at 1-800-635-5271 for out-of-state providers and 1-800-392-7038 for in-state providers. Providers in the Helena area can call 444-8550.
197		69	Claim denied. NDC requires prior authorization.
197		86	Claim denied. Diagnosis requires prior authorization.
197		142	Claim/line denied: revenue code requires prior authorization.
197		153	Service denied. The services authorized under this prior authorization were previously processed against this prior authorization record causing this record to be used and no longer available. Please request approval for additional services.
197	N45	474	Services denied. The change in the units or dollar amounts on this adjustment exceeds the authorized amounts, or this is an adjustment that was previously denied due to a problem with the prior authorization. Contact your approving agency for assistance with units or dollar authorized amount questions. Otherwise, contact ACS for assistance.
198		81	Service denied. The amount billed is greater than the amount authorized. For assistance contact the approving agency.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
198	N54	113	Service denied. The number of units billed is greater than the number of units authorized or you are billing with a cancelled prior authorization number. For assistance, please contact the approving agency.
198		170	This drug is outside the formulary and requires prior authorization. If you have not resolved this condition contact the drug prior authorization unit at 800-395-7961 or 406-443-6002.
198	M62	866	Claim/line denied. At least one service on this claim requires prior authorization. Resubmit the claim with a valid prior authorization number.
211	M119	236	NDC required but is missing, invalid, not rebateable or DESI 5 or 6 or modifier 'KP' is on the line, indicating there should be an attachment with multiple NDCs for the line.
211	N60	847	Drug claim denied. This drug has no price on file for the date filled. Either the NDC is obsolete or the manufacturer does not have a signed rebate agreement with Medicaid.
216		169	Claim denied. Drug utilization review (DUR) reject error.
226	M53	6	The number of units billed in field #46 for accommodation days does not equal the number of days in the date of service span identified in field #6. Please correct the claim and resubmit.
226	N3	73	The federal sterilization consent form or documentation of prior sterility is required, but was not present with the claim form. Please attach a copy of either the completed sterilization consent form or documentation of prior sterility to the claim and resubmit.
226	N3	75	Federal hysterectomy acknowledgement form or other approved attachment(s) was not attached to the claim. A completed copy of the federal hysterectomy acknowledgement form (MA-39) or other approved attachment(s) is required before payment can be considered. Please resubmit with a copy of the completed hysterectomy form or other approved attachments (please refer to your provider manual).
226	N3	79	Claim denied. Proper documentation was not attached to the claim. Please complete the MA-037 form and resubmit. For more information, refer to the family planning section of your Medicaid provider manual. Complete medical record is to be forwarded for federal medical review to physician services, health policy and services division.
226	M143	303	This claim has been denied because you have not responded to our recent letter. To resolve the problem, please resubmit the claim to the Provider Relations staff at ACS with a copy of your current license attached to the front of the claim. Mail the claim and license copy to Provider Relations at P.O. Box 4936, Helena, MT 59604.
226	N28	799	Any correspondence related to hysterectomy and sterilization, including any operative reports, must be personally signed and dated by the physician.
226	M53	801	The number of days shown on the claim exceeds the number of days in the date of service span. Please correct the claim and resubmit.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
226	N28	807	Section 'A' hysterectomy form error -- the recipient name, the recipient signature/date, or physician signature/date are missing or the signatures are not within the required time frames. For dates of service 7/1/03 and after, the signatures must be obtained at least 30 days prior to the surgery. For dates of service 6/30/03 and prior, the signatures must be obtained before the surgery or within 30 days following the surgery.
226	N228	808	Claim denied. The sterilization consent form was not personally signed and dated by the patient. This claim does not meet federal requirements for payment of sterilization procedures.
226	N28	809	Claim denied. The patient was not 21 years of age or older at the time the sterilization consent was obtained. Medicaid regulations do not allow for any exceptions to this age requirement. If necessary, contact the county office for verification of the birth date.
226	N205	810	The consent form is not legible. Please resubmit the claim with a legible copy of the sterilization consent form attached.
226	N228	811	The sterilization consent form is incomplete. Please complete all fields on the form. Refer to the family planning section of your provider manual for specific instructions. (The interpreter's statement must be completed only when the patient needs an interpreter.)
226	N28	812	Date of sterilization is 180 days or more from date consent signed by recipient. The recipient's consent is valid for a maximum of 180 days.
226	N28	813	The person obtaining the consent must have signed and dated the consent form on the same date the recipient signed, at least 30 days prior to the sterilization procedure. Please refer to the family planning section of your provider manual for instructions on completing the sterilization consent form.
226	N28	814	The date of service on the claim does not agree with the procedure date as shown on the sterilization consent form. Please refer to your family planning provider manual for specific information on consent forms.
226	N28	815	Claim denied. Sterilization is not covered by Medicaid if the recipient is mentally incompetent or institutionalized. If needed, attach explanation signed by the physician to the claim and consent form and resubmit.
226	N28	816	The physician's signature on the sterilization consent form must be dated on or after the date the sterilization was performed. Please refer to the family planning section of your provider manual for specific information on consent forms.
226	N28	817	The expected date of delivery must be reflected on the consent form in cases of premature delivery. The informed consent must have been given at least 30 days before the expected date of delivery.
226	N28	818	Claim/line denied. Sterilization was performed within 72 hours of obtaining consent.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
226	N3	824	There must be at least 30 days between date of recipient signature on the sterilization consent form and the date the sterilization was performed. If premature delivery or emergency abdominal surgery occurred in this case, attach to the claim and consent form medical records signed by the physician which document the medical situation.
226	N3	825	Sterilization is indicated on the claim. Resubmit with a properly completed consent form. Hysterectomy acknowledgement or other unapproved forms cannot be substituted for an approved sterilization consent form. Please refer to the family planning section of your provider manual.
226	N205	842	The authorization copy which you attached to this claim was either illegible or incomplete. Please attach a complete, legible copy of the authorization to your claim form and resubmit.
226	N28	851	The consent form appears to have been altered. Please attach a letter of explanation and resubmit claim, consent form and letter.
226	N28	857	Claim denied. Patient must sign and date the patient certification section(s) on the abortion certification form.
226	N29	859	This claim has been denied because the claim information indicates that an abortion may have been performed. If there was no abortion, please resubmit the claim with a statement signed by the physician attesting that a non-spontaneous abortion did not result from the procedure.
226	N206	860	Attachments do not correspond to claim with which they were ICN'ed. Removed and resubmitted.
226	N228	864	Consent form not completed correctly. Refer to the family planning section of your provider manual for instructions.
226	N362	875	Claim/line denied. The number of units billed for this service is more than the number of units that were authorized. Please correct the units of service and resubmit.
226	N228	880	The recipient's date of birth on the consent form is inconsistent with that on the Medicaid eligibility file. To reconsider the claim, attach an explanation or a birth certificate.
226	N28	881	The person obtaining the consent did not sign, date or list their mailing address. Please correct and resubmit.
226	N517	883	Claim denied. Requested information has not been received.
226	N28	884	Claim denied. Physician must sign and date the physician certification section(s) on the abortion certification form.
226	N228	894	Claim/line denied. The sterilization consent form is incomplete. The date the procedure was performed is missing. All fields on the consent form must be completed for Medicaid to make payment. Please resubmit the claim with a complete copy of the consent form.
226	N228	907	Claim denied. The date of the sterilization procedure under the physician's statement heading on the sterilization consent form is missing or invalid.
A8		208	Claim denied. The procedure and diagnosis information provided on this claim cannot be assigned a correct DRG code. Please review diagnostic and procedure code information and correct if necessary. If correct, contact the Hospital Program Officer, Health Policy Services Division, Department of Public Health and Human Services. (406-444-4540)

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
A8		308	Claim first date of service is older than July 1, 1996 and will not group/price in our system. Please contact the Department with any problems.
B13	M86	18	Claim or line denied. You may have already billed and been reimbursed for the same or similar service for this patient. Please check your records before resubmitting to the Provider Relations Department with an explanation.
B13	M86	100	Claim or line denied. This service or a related service performed on this date has already been billed by another provider and paid. Please verify the accuracy of the procedure code and the presence of the appropriate procedure code modifier before cont acting ACS for assistance.
B13		195	Services denied. Case management services have previously been billed and paid during this month.
B13	M2	201	Claim denied. The services for this claim are bundled in another payment.
B15	N56	74	Claim denied. This procedure cannot be split into professional and technical components. It must be submitted as one complete service before payment can be considered.
B15		230	This service is part of another procedure and is not paid separately.
B22	N208	205	Claim denied. DRG code is not allowable.
B22	MA63	207	Claim denied. Primary diagnosis provided on claim is invalid as a discharge diagnosis. Please check the diagnosis and correct this code before resubmitting the claim.
B22		904	Claim/line denied. The diagnosis code reference number (pointer) is either missing or invalid. Please correct and resubmit.
B5		155	Claim/line denied. EPSDT indicator on the claim/line not valid for this recipient. Please correct and resubmit.
B5		252	Provider cannot bill "encounter" claims.
B5		434	Claim/service denied/reduced because coverage/program guidelines were not met or were exceeded.
B5	N30	438	Claim denied. This recipient is on the FAIM (BASIC) program and the service billed is not part of that program.
B5		826	Denied. Medicaid does not replace lost or stolen glasses.
B5	M42	882	Sections 'B' or 'C' hysterectomy form error -- the recipient name, the cause of the sterility or nature of the emergency, and/or physician signature and/or date are missing.
B7	N256	39	Services denied. The billing provider was either not present on the claim or not active on the dates of service, please confirm the dates of service, correct and resubmit. If the dates of service are correct, contact Provider Relations at ACS, 1-800-624-3958 or 406-442-1837 to correct or complete your enrollment.
B7		42	Services denied. The effective date of your enrollment is after the date of service. Please verify the dates of service, correct and resubmit. If the dates of service are correct, contact Provider Relations at ACS, 1-800-624-3958 (in state only) or 406-442-1837 for assistance.
B7		99	This recipient is restricted and the billing and/or the prescribing physician is not the primary provider.

Claim Adjustment Reason Code	Remittance Advice Remark Code	MMIS EOB Code	MMIS EOB Description
B7		130	Claim denied. One of the following conditions exists on the claim: the provider is not authorized to perform the category of service billed; the dates of service are not within the category of service dates on the provider master file; or the services are being billed on the wrong claim form.
B7	MA120	131	Claim/line denied. Provider not authorized to perform this lab class service under Medicare/Medicaid.
B7	MA120	318	Services denied. The CLIA number is invalid or the provider's certification type is not valid for this service. Please verify ACS has the current CLIA number. Then correct and resubmit.
B7		916	Claim rendering provider number does not match the provider number on the client's nursing home span.
B7		952	Claim denied. Please verify the services were billed with the correct provider number.
D18	N434	522	The present on admission indicator for the diagnosis code is either missing or invalid