GENERAL APPENDIX 5
ERROR CODE EXPLANATIONS

Error Code	Message	Explanation
A10	Payee Code Not Equal To Payee #1 (LEA)	The Payee Code received on the claim must always be "1" for LEA Providers
A12	Refill Too Soon Carry Over Days Supply	The system detected a pattern of refills where insufficient quantities of the previous prescriptions were consumed prior to the dispensing of the refill. Based on the participant's fill history of the particular drug being billed, the patient should have a sufficient supply of the drug. The patient should modify their prescription filling pattern in order to avoid continued rejections. The provider may request a Refill-Too-Soon (RTS) override if valid justification exists. If the RTS override request is approved, resubmit the claim.
A13	Refill Too Soon LTC Carryover Day Supply	This edit is specific to residents of Long Term Care (LTC) facilities. The system detected a pattern of refills where insufficient quantities of the previous prescriptions were consumed prior to the dispensing of the refill. Based on the participant's fill history of the particular drug being billed, the patient should have a sufficient supply of the drug. The patient should modify their prescription filling pattern in order to avoid continued rejections, or the pharmacy should modify their refill pattern. The provider may request a Refill-Too-Soon (RTS) override if valid justification exists. If the RTS override request is approved, resubmit the claim.

A15	RTS Exceeds Monthly Maximum Quantity LTC	This edit is specific to residents of Long Term Care (LTC) facilities. Based upon the Department's records for paid services for this participant, the current prescription's quantity added to the quantities for previously paid services in the same therapeutic class, exceeds the recommended monthly maximum quantity for products in this class. The provider may request a Refill-Too-Soon (RTS) override if valid justification exists. If the RTS override request is approved, resubmit the claim.

Error Code	Message	Explanation
A16	RTS Exceeds Monthly Maximum Quantity	Based upon the Department's records for paid services for this participant, the current prescription's quantity added to the quantities for previously paid services in the same therapeutic class, exceeds the recommended monthly maximum quantity for products in this class. The provider may request a Refill-Too-Soon (RTS) override if valid justification exists. If the RTS override request is approved, resubmit the claim.
A19	Payment Denied Exceeds LOS Certification	The covered days on the claim are greater than the total length of stay as determined by the department's peer review organization. Review the certification/continued stay information received from the PRO and compare it to the covered/non-covered date information on the claim.
A22	More Specific Diagnosis Required	An institutional claim was submitted with an obsolete diagnosis code(s).
A23	More Specific Procedure Code Required	An institutional claim was submitted with an obsolete procedure code(s).
A24	Not A Preferred Drug Call 1-800-252-8942	The product being billed is not a preferred drug. The Preferred Drug List is posted to the Department's Web site at http://www.hfs.illinois.gov/preferred/. Pharmacist should contact the prescriber to determine whether the patient can be switched to a preferred drug. If patient cannot be switched to a preferred drug, provider should submit a prior approval request for the non-preferred drug. If the prior approval request is approved, resubmit the claim.
A25	Preferred Drug Call 1-800-252-8942 For PA	The product being billed is a preferred drug, but is in a therapeutic class that requires prior approval. Provider should submit a prior approval request. If the prior approval request is approved, resubmit the claim.
A29	Concurrent/Continued Cert Required	Mandated concurrent/continued stay certifications of admission is not posted to the department's database with a matching RIN, provider ID, admitting diagnosis code, and admit date.

Error Code	Message	Explanation
A30	Bill Multi-Eligibility Segments on Separate Claims	**NIPS Only**. A claim has been received for a participant who is eligible for FamilyCare for one of the dates of service and eligible for regular Medicaid on another date of service. The FamilyCare dates of service must be submitted on a separate claim than the regular Medicaid dates of service.
A31	Recipient Eligible For Moms And Babies	A claim was submitted with a procedure code for an abortion and the client has eligibility coverage under the Moms and Babies program.
A32	NDC Not Covered For Critical Care Provider	The product is not covered when billed by a Critical Care Provider.
A36	Coins + Ded > IDPA Allowed Amount	The amount of Coinsurance and Deductible remaining after adjudication by Medicare exceeds the Department's maximum allowable for the billed NDC.
A38	Missing/Invalid Taxonomy Code	A claim was submitted without a taxonomy code or an invalid taxonomy code. Review and resubmit claim with the appropriate taxonomy code. Refer to the taxonomy codes in Chapter 300, Appendices 4 and 5. If the claim was submitted with the correct taxonomy code, contact a billing consultant for assistance.
A39	APL/HCPCS Code Required on Claim	The claim does not contain at least one APL HCPCS code; or revenue code 450, 451, 456, or 762; or does not meet the criteria of being a DCFS screening claim.
A40	Invalid Void or Void/Rebill Transaction	The information submitted on the void/rebill cannot be matched to an original claim. Review and resubmit void/rebill with the appropriate information.
A41	Void/Rebill is Past Timely Filing	A void/rebill was submitted more than twelve (12) months after the voucher date on the previously paid claim. The Department will not reprocess claims received more than twelve (12) months after the original voucher date.

Error Code	Message	Explanation
A43	Not Covered/ Illinois Healthy Women Family Plan Service	A claim was submitted for a procedure not covered by the Illinois Healthy Women Program. Review the medical record. If a family planning diagnosis code in the V25 range should have been reported, rebill using the correct code. If no error was made on the original claim, do not rebill. No payment can be made.
A44	Inconsistent Service Date	Applies to outpatient claims with dates of service on and after 07/01/04. The Revenue Code service line date is prior to the From Date or after the Through Date. Hospice claims with dates of service on and after 01/01/2007. For any Revenue Code 652, if the service line date is blank or the service date is prior to the From Date or after the Through Date or claim has multiple Revenue Code lines 652 with the same service date. Claims with Revenue Codes 651, 655, 656, 657or 658 if the service line date is prior to the From Date or after the Through Date.
A48	SASS Involvement Required	Institutional Only. SASS involvement is required for all covered days submitted. Review dates of service billed on the claim.
A49	Discharge Planning Involvement Required	Institutional Only. The claim was denied as department files indicate there was no SASS involvement in discharge planning.
A50	Service Not Covered Without Modifier U1	A claim was submitted for procedure code 36415 and no modifier. This procedure code is only covered when billed for blood lead draw and accompanied by the state defined “U1" modifier.
A51	Service Allowed For FQHC/ERC/RHC Only	A claim was submitted with procedure code T1015. This procedure code is only covered for FQHC, RHC or ERC provider types.

Error Code	Message	Explanation
A52	Transportation Modifier Invalid for Service	A claim was submitted with a modifier designated for emergency transportation only. However, the provider taxonomy or COS submitted on the claim is not emergency transportation. Review medical record to determine the correct billing information.
A53	Bill Multi-CMH Eligibility on Separate Claims	A claim has been received for a participant who is enrolled in the Community Mental Health Services (CMH) program for one date of service and eligible for regular Medicaid on another date of service. The CMH dates of service must be submitted on a separate claim than the regular Medicaid dates of service.
A54	CMH - No Certification on File	Institutional Only. The claim was denied as there was no PRO certification that matches the provider ID, RIN, admitting diagnosis, and admit date; and length of stay is greater than one day.
A56	CMH - One Day Stay	Institutional Only. Claim was denied as department files indicate no CARES or SASS involvement.
A57	Duplicate of Encounter Claim	The client is enrolled in a Medicaid Managed Care Plan.
A59	Procedure/Modifier/POS Combination Invalid	A claim was received with a Procedure/Modifier/Place of Service combination not recognized by HFS.
A60	Service Not Covered-Bill as DME Claim	Wound care dressings and related supply items must be billed as a medical equipment/supply item using either the HIPAA 837P electronic billing format, or on paper using the Department's Form HFS 2210 (Medical Equipment/Supplies) invoice; or by submitting the same data through the Department's MEDI (Medical Data Interchange) system. Note that wound care dressings are not covered for residents of LTC facilities. They are the responsibility of the facility.
A62	NDC Not Covered	The product is not covered by the Pharmacy Program. Examples of non-covered items are drugs indicated only for the treatment of erectile dysfunction.

Error Code	Message	Explanation
A66	Bill Fluoride Varnish Separately	A claim was submitted with procedure code D1203 in conjunction with other procedure codes and/or more than one occurrence of D1203. Procedure Code D1203 must be billed separately, with no other procedure codes.
A71	Service not Authorized in Contract	Billable Services restricted to Provider Type 036, Community Mental Health.
A76	DHS Recipient Only - Review Claim	The Recipient is not Medicaid eligible. Coverage is only through the Department of Human Services (DHS), which requires the claim to suspend for DHS review to ensure that a Medicaid application has been completed for the recipient before payment can be made.
A77	No Medicaid Application was Filed	Provider did not complete a MANG application for the client.
A79	Interagency PMT AMT Unacceptable	The interagency payment amount is zero or exceeds the department's allowable amount.
A82	Service is not Payable by HFS	A claim was submitted for a client that has a case identification office number of 195, which identifies that the client is an IDOC or IDJJ inmate. IDOC or IDJJ is responsible for payment. Providers may contact HFS at 217-782-3541 for IDOC/IDJJ medical vendor information.
A83	Suspended for DHS Review	This error occurs for children who are only eligible for SASS services. The claim suspends for DHS to review to see if a Medicaid/All Kids application has been filed or if there is an exemption on file.
A88	No Certification on File	Institutional inpatient claims only. A claim was submitted with an admitting diagnosis code that requires the provider to contact HSI for an admission/concurrent continued stay review prior to inpatient admission.

Error Code	Message	Explanation
A90	Invalid Technical/ Prof Component Billing	A claim was received from a hospital, ASTC, lab or imaging center requesting reimbursement for the professional component only. The department only reimburses a hospital, ASTC, lab or imaging center for the technical component or the global. A claim was received from a physician requesting the global or technical component with place of service inpatient hospital, outpatient hospital, emergency room or ASTC. The department will only reimburse a physician for the professional component when the procedure is performed in the following place of service inpatient hospital, outpatient hospital, emergency room or ASTC.
A91	OTC Drug not Covered for All Kids Recip	The drug being billed is an over-the-counter (OTC) item. The participant is enrolled in the All Kids Premium Program on the date of service. The Department does not reimburse for most OTC items for individuals enrolled in the All Kids Premium Program, (Levels 2 through 8).
A97	Void/Rebill Hold	The void/rebill has been temporarily suspended for Department review. Do not resubmit. The final status will be reported on a future Remittance Advice.

Error Code	Message	Explanation
B04	Qty Dispensed Exceeds Qty Prescribed	A claim was received with a value in the quantity Dispensed Field (442-E7) that is greater than the value received in the Quantity Prescribed Field (460-ET). Please review dispensing records. Submit a new claim with the correct values in these fields.
B05	Dispensing Status not P C or Blank	The claim was billed with a value in the Dispensing Status Code field that was not “P”, “C,” or a blank (not a partial fill). Please review dispensing records. Submit a new claim with the correct values in these fields.
B06	No Partial for Completion this Rx	The claim was billed with a value of “C” (completion) in the Dispensing Status Code (343-HD) field. The Department’s records do not contain a paid service with a value of “P” (Partial) in the Dispensing Status Code field for this prescription number. Check dispensing records to ensure that a paid response was received from the Department for a Partial fill. If a paid partial fill record exists, contact a Pharmacy billing consultant at 1-877-782-5565, option 7. If no paid partial fill exists, submit the partial dispensing claim and then, after the paid response is received, submit the completion dispensing claim.
B07	Multiple Partial Fills not Allowed	The claim was billed with the dispensing Status Code (343-HD) field marked as a partial fill. Department records indicate a previously paid partial fill for this prescription number, NDC and date of service. Only one partial fill is allowed for a given prescription. If you are unable to identify the previously paid partial fill, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7.
B10	Invalid Quantity to be Dispensed	The claim was submitted with either non-numeric values or spaces in the Quantity Intended to be Dispensed (344-HF) field when this field is situationally required. Review billing records for the correct value for this field. Resubmit claim with correct values. If there is a question about when this field should be completed, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance.

Error Code	Message	Explanation
B11	Invalid Days Supply to be Dispensed	The claim was submitted with either non-numeric values or spaces in the Days Supply Intended to be Dispensed (345-HG) field when this field is situationally required. Review billing records for the correct value for this field. Resubmit claim with correct values. If there is a question about when this field should be completed, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance.
B12	Qty to be Dispensed < Qty Dispensed	The value in the Quantity Intended to be Dispensed (344-HF) field that is less than the value in the Quantity Dispensed (442-E7) field. Review dispensing records to determine which value is in error. Resubmit the claim with the correct values
B13	Day Sup to be Dispensed<Day Sup Disp	The value in the Days Supply Intended to be Dispensed (345-HG) field that is less than the value in the Days Supply Dispensed (405-D5) field. Review dispensing records to determine which value is in error. Resubmit the claim with the correct values.
B14	Invalid Prescriber ID Qualifier	The value in the Prescriber ID qualifier (466-EZ) field does not match a valid value in the NCPDP 5.1 Data Dictionary. For electronic submissions, please contact your software vendor to determine whether the value you are using is correct. For paper submissions, refer to the paper invoice billing instructions for the HFS 215 Drug Invoice for the completion of this field.
B15	Missing Prescriber Last Name	The Prescriber Last Name (427-DR) field is not completed. This is a required field. Please resubmit the claim with this field completed.
B16	Invalid Primcare Physician ID Qualifier	The value in the Primary Care Physician ID Qualifier field does not match a valid value in the NCPDP 5.1 Data Dictionary. For electronic submissions, please contact your software vendor to determine whether the value you are using is correct. For paper submissions, refer to the paper invoice billing instructions for the HFS 215 Drug Invoice for the completion of this field. Resubmit the claim with valid values.

Error Code	Message	Explanation
B17	Primcare Physician Invalid for Qualifier	The participant is locked into a Primary Care Physician (PCP) on the date of service. Based on the Primary Care Physician Qualifier and the Primary Care Physician Identifier received, the Department was unable to identify the PCP in our files. Review billing records to ensure that these two fields are correct. If data was in error, resubmit the claim with corrected information. If data was correct, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance.
B21	Invalid Compound Route of Administration	The claim is coded as a compound. The value in the Compound Route of Administration (452-EH) field does not match a valid value in the NCPDP 5.1 Data Dictionary. For electronic submissions, please contact your software vendor to determine whether the value you are using is correct. For paper submissions, refer to the paper invoice billing instructions for the HFS 215 Drug Invoice for the completion of this field. Resubmit the claim with a valid value.
B22	Other Payer Date > Process Date	The claim was submitted with a date in the Other Payer Date (443-E8) field that is later than the date on which the Department received the claim. Please review dispensing records to identify the correct date that the other payer notified you of the disposition of the claim. Correct the Other Payer Date and resubmit the claim.
B24	Compound NDC not on HFS File	The claim is coded as a compound. The value in the Compound Product ID (489-TE) field for one of the ingredients does not match a valid value in the Department's NDC database. Please review dispensing records to verify that the correct NDC values were submitted. If an error was found please resubmit with the correct NDC. If the NDCs submitted were correct, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance in identifying the NDC in error.

Error Code	Message	Explanation
B26	Compound NDC Determined Obsolete	The claim is coded as a compound. The date of service for the compound is greater than three years after the obsolete date for one of the ingredients in the compound. The pharmacy may, at their option, resubmit the compound with either the Submission Clarification value of 08 (Process Compound for Approved ingredients) or substitute a therapeutically equivalent drug.
B27	Brand Name Limit Exceeded	A claim for a brand name drug was billed for a participant for whom the Department has already reimbursed for three brand name drugs in the previous 30 days. Pharmacist should contact prescriber to see if patient can switch to an alternative generic drug. If prescriber and pharmacist determine that patient cannot be switched to an alternative generic drug, provider must submit a prior approval request for a Three Brand Name Drug Limit override. The provider must include sufficient clinical documentation to support the request.
B28	Compound NDC Price not on HFS File	The claim is coded as a compound. An error exists for one of the billed ingredients. Please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance, when this error is received.
B29	Manufacturer not Eligible for Quarter	The claim is coded as a compound. The manufacturer of one of the ingredients does not have a valid rebate agreement on file with the federal Centers for Medicare and Medicaid Services (CMS) for the quarter in which the Date of Service falls. The Department can only reimburse for drugs manufactured by companies who have signed rebate agreements with CMS. A listing of manufacturers with signed rebate agreements is available on the Department's Web site. Please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, to determine which ingredient failed the edit. The pharmacy may, at their option, resubmit the compound with the Submission clarification value = 08 (Process Compound for Approved Ingredients).

Error Code	Message	Explanation
B30	Invalid Other Payer Coverage Type	A TPL/COB situation was reported, with a value of other than '01', '02', '03', or '99' in the Other Payer Coverage Type (338-5C) field, or if the Other Payer Coverage Type field has a value of '99', then the Other Payments Count field (337-4C) must always equal "1." Review billing records to determine the source of the error. Resubmit the claim with the correct values as defined. If the data appears correct, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7.
B32	Other Payer ID Qualifier not Equal 99	A claim was received, reporting a TPL/COB situation, with a value of other than '99' in the Other Payer ID Qualifier (339-6C) field. Review billing records to determine the source of the error. Resubmit the claim with the correct value as defined. If the data appears correct, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7.
B33	Invalid TPL ID Code	The value in the other Payer ID field (340-7C) does not match a value in either the Department-assigned 3 character TPL Master table or the PBM (Pharmacy Business Manager) table. Both of these tables are found in Chapter 100 on the Department's Web site. Appendix 15 (Third Party Liability Resource Code Directory) is the TPL Master table and Appendix 14 (TPL/PBM Resource Code directory) is the PBM table. The preference is to use coding from Appendix 14 first. If no match can be found in Appendix 14, please use a value from Appendix 9. Any questions related to correct coding should be referred to a Pharmacy billing consultant at 1-877-782-5565, option 7.
B35	Other Payer Amt Pd Qualifier not Equal 08	The value in the Other Payer Amount Paid (431-DV) field is greater than zero and the value in the Other Payer Amount Paid qualifier field (342-HC) does not equal 08. Review billing records to determine the source of the error. Resubmit the claim with the correct value as defined. If the data appears correct, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance.
B54	Not an IL Cares Rx Basic Covered Service	The participant is enrolled in the Illinois Cares Rx Basic program, and the drug is not covered under this program.

Error Code	Message	Explanation
B58	Reason for Service Code Invalid	The value in the Reason for Service (439-E4) field does not match a valid value in the NCPDP 5.1 Data Dictionary. For electronic submissions, please contact your software vendor to determine whether the value you are using is correct. The Department does not require this element to process a claim so the pharmacy may, at their option either correct the value and resubmit the claim or delete the value from the field and resubmit the claim.
B59	Professional Service Code Invalid	The value in the Professional Service Code (440-E5) field does not match a valid value in the NCPDP 5.1 Data Dictionary. For electronic submissions, please contact your software vendor to determine whether the value you are using is correct. The Department does not require this element to process a claim so the pharmacy may, at their option either correct the value and resubmit the claim or delete the value from the field and resubmit the claim.
B60	Result of Service Code Invalid	The value in the Result of Service (441-E6) field does not match a valid value in the NCPDP 5.1 Data Dictionary. For electronic submissions, please contact your software vendor to determine whether the value you are using is correct. The Department does not require this element to process a claim so the pharmacy may, at their option either correct the value and resubmit the claim or delete the value from the field and resubmit the claim.
B62	Not Eligible For Part D Copay Billing	The participant is eligible for Medicare Part D on the date of service, but the participant is not eligible for payment of their Medicare Part D copays.
B63	Compound Prior Approval not on File	The claim is coded as a compound. One of the ingredients requires prior approval but no prior approval matching the product was found. If a drug requires prior approval when billed individually, it requires prior approval when billed as an ingredient in a compound. The pharmacy may, at their option, resubmit the compound with the Submission Clarification value = 08 (Process Compound for Approved Ingredients) or request prior approval for the ingredient prior to resubmitting the compound.

Error Code	Message	Explanation
B64	Compound PA not on File for Fill Date	The claim is coded as a compound. One of the ingredients requires prior approval but no prior approval matching the product was found for the date of service. If a drug requires prior approval when billed individually, it requires prior approval when billed as an ingredient in a compound. The pharmacy may, at their option, resubmit the compound with the Submission Clarification value = 08 (Process Compound for Approved Ingredients) or request prior approval for the ingredient prior to resubmitting the compound.
B66	Compound Item Group Care Restricted	The claim is coded as a compound. One of the ingredients in the compound can only be reimbursed by the Department when the participant is not a resident of a Long Term Care facility. Department records indicate that the participant was not residing in a LTC facility on the date of service. Review billing records to ensure that the correct date of service was submitted. If the date of service was in error, resubmit the claim with the correct date. If the date of service was correct, the pharmacy may, at their option, resubmit the compound with the Submission Clarification value = 08 (Process Compound for Approved Ingredients). If you have questions regarding this error, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance.
B67	Compound Item not Covered for Aid Category	The claim is coded as a compound. One of the ingredients is not reimbursable because the participant is over the age of 18 and is covered under the General Assistance program, or the participant is classified as a non-citizen receiving renal dialysis treatment. The pharmacy may, at their option, resubmit the compound with the Submission Clarification value = 08 (Process Compound for Approved Ingredients). If you have questions regarding this error, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance.

Error Code	Message	Explanation
B68	Compound Quantity Exceeds HFS Maximum	The claim is coded as a compound. The billed quantity for one of the ingredients in the compound exceeds the Department's maximum allowable quantity for the NDC. The provider may submit a prior approval request, to request a maximum quantity override. If the maximum quantity override is approved, the claim may be resubmitted.
B69	Compound Quantity Less Than HFS Minimum	The claim is coded as a compound. The billed quantity for one of the ingredients is less than the Department's minimum allowable quantity for the NDC. The pharmacy may submit a prior approval request, to request a minimum quantity override. If the minimum quantity override is approved, the claim may be resubmitted.
B72	Compound Item Invalid for Recipient Sex	The claim is coded as a compound. One of the ingredients in the compound is not appropriate for the gender of the participant. The pharmacy should review claim for accuracy. If the billing data is in error, it should be corrected and the claim resubmitted. If the billing data is correct, the pharmacy may, at their option, resubmit the compound with either the Submission Clarification value = 08 (Process Compound for Approved Ingredients) or submit a prior approval request for a gender override. If the gender override is approved, the claim may be resubmitted.
B73	Compound Item Invalid for Recipient Age	The claim is coded as a compound. One of the ingredients is not appropriate for the age of the participant. The pharmacy should review the claim for accuracy. If the billing data is in error, it should be corrected and the claim resubmitted. If the billing data is correct, the pharmacy may, at their option, resubmit the compound with either the Submission Clarification value = 08 (Process Compound for Approved Ingredients), or submit a prior approval request for an age limit override. If the age limit override is approved, the claim may be resubmitted.

Error Code	Message	Explanation
B75	Compound DESI Drug not Allowed	The claim is coded as a compound. One of the ingredients is identified as being in DESI status on the date of service. The Department cannot reimburse for DESI drugs. The pharmacy may, at their option, resubmit the compound with the Submission Clarification value = 08 (Process Compound for Approved Ingredients). The Department cannot reimburse for DESI drugs.
B76	Compound MFGR not on File for Rebate	The claim is coded as a compound. The manufacturer of one of the ingredients does not have a valid rebate agreement on file with the federal Centers for Medicare and Medicaid Services (CMS). The Department can only reimburse for drugs manufactured by companies who have signed rebate agreements with CMS. A listing of manufacturers with signed rebate agreements is available on the Department's Web site. Please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, to determine which ingredient failed the edit. The pharmacy may, at their option, resubmit the compound with the Submission clarification value = 08 (Process Compound for Approved Ingredients).
B77	Compound MFGR not on FILE for Rebate/DOS	The claim is coded as a compound. The manufacturer of one of the ingredients does not have a valid rebate agreement on file with the federal Centers for Medicare and Medicaid Services (CMS) for the quarter in which the Date of Service falls. The Department can only reimburse for drugs manufactured by companies who have signed rebate agreements with CMS. A listing of manufacturers with signed rebate agreements is available on the Department's Web site. Please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, to determine which ingredient failed the edit. The pharmacy may, at their option, resubmit the compound with the Submission clarification value = 08 (Process Compound for Approved Ingredients).

Error Code	Message	Explanation
B78	Compound NDC Approval not on HFS File	The claim is coded as a compound. One of the ingredients requires prior approval, and there is no prior approval on file. If an NDC requires prior approval when billed individually, it requires prior approval when billed as an ingredient in a compound. The pharmacy may, at their option, resubmit the compound with either the Submission Clarification value = 08 (Process Compound for Approved Ingredients) or request a prior approval for the ingredient.
B79	Compound NDC was Terminated on *	The claim is coded as a compound. One of the ingredients is identified on the Department's files as having a termination date prior to the date of service. The Department cannot reimburse for drugs after their date of termination. The pharmacy may, at their option, resubmit the compound with either the Submission Clarification value = 08 (Process Compound for Approved Ingredients) or substitute a therapeutically equivalent drug that is not terminated. If questions arise, please contact a Pharmacy billing consultant at 1-877- 782-5565, option 7 for assistance.
B80	Compound Item Part B -Bill Medicare	The claim is coded as a compound. The participant has Medicare Part B coverage on the date of service. One of the ingredients is identified on the Department's files as being covered under Medicare Part B on the date of service. The pharmacy must first submit the claim to Medicare for adjudication. After Medicare adjudication, the claim should be submitted to the Department, with the TPL/COB elements completed, indicating the disposition of the claim by Medicare. If questions arise, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7 for assistance.
B81	COMPOUND NDC PPU IS EQUAL ZEROS	The claim is coded as a compound. One of the ingredients contains a pricing error on the Department's files. Please contact a Pharmacy billing consultant at 1-877-782-5565, option 7 prior to resubmitting the claim.

Error Code	Message	Explanation
B83	Compound Item is not Preferred Drug	The claim is coded as a compound. One of the ingredients is not a preferred drug. The Preferred Drug List is posted to the Department's Web site. The pharmacy may, at their option, resubmit the compound with either the Submission Clarification value = 08 (Process Compound for Approved Ingredients), or request prior approval for the ingredient prior to resubmitting the compound, or substitute a preferred drug for the ingredient that is non-preferred.
B84	Compound Item Preferred Drug- PA Required	The claim is coded as a compound. One of the ingredients is a preferred drug that requires prior approval. The pharmacy may, at their option, resubmit the compound with either the Submission Clarification value = 08 (Process Compound for Approved Ingredients) or request prior approval for the ingredient prior to resubmitting the compound.
B90	Other Payment Segment not Allowed	Electronic submittal only: A value was submitted in the Other Coverage Code (308-C8) field indicating that no other insurance coverage exists for this claim. This conflicts with the submittal of insurance information in the TPL / COB fields. Please review billing records. If no other insurance exists, resubmit claim without information in the TPL / COB fields. If there was prior adjudication of the claim by another insurance carrier, it must be reported in the TPL COB fields. The value in the Other Coverage Code field should be changed to reflect the appropriate condition before rebilling. Detailed information regarding the coding requirements for TPL /COB reporting is available on the Department's Web site at Topic 304 (NCPDP Companion Guide). See Section 304.5 (Third Party Liability). If you have questions regarding correct coding, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7 for assistance.

Error Code	Message	Explanation
B91	Invld Other Payer Amt Pay for Cover Code	The claim contained a value of either "02" (Other Coverage Exists - Payment Collected) or "08" (Claim is billed for CoPay) in the Other Coverage Code (308-C8) field, but the Other Payer Amount Paid (431-DV) value is blank or contains zeros; or the claim contains a value of "04" (Other Coverage Exists - Payment not collected) and the Other Payer Amount Paid value is greater than zeros. Detailed information regarding the coding requirements for TPL /COB reporting is available on the Department's Web site at Topic 304 (NCPDP Companion Guide). See Section 304.5 (Third Party Liability). If you have questions regarding correct coding, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7 for assistance.
B92	Invld Other Payer Rej Cd for Cover Code	The claim was billed with a value of either "03" (Other Coverage exists - claim not covered) or "05" (Managed Care Plan Denial) or "06" (Other Coverage Denied - not a participating provider) or "07" (Other coverage exists - not in effect on Date of Service) in the Other Coverage Code (308-C8) field, and either the Other Payer Amount Paid (431-DV) value is greater than zeros or the value in the Other Payer Reject Code (472-6E) field is not a valid NCPDP rejection code. Please check the billing records and change the above referenced fields prior to rebilling. Detailed information regarding the coding requirements for TPL /COB reporting is available on the Department's Web site at Topic 304 (NCPDP Companion Guide). Then see Section 304.5 (Third Party Liability). If you have questions regarding correct coding, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7 for assistance.
B93	Other Payment Segment Required	

Error Code	Message	Explanation
B94	Part D Service – Bill Medicare	The participant is eligible for Medicare. The claim must be submitted to the participant's Medicare Part D Prescription Drug Plan (PDP). This drug is not eligible for coverage by the Department for a Medicare-eligible individual. The participant must adhere to the PDP's formulary.
B95	NDC not Cvrd for Part D Copay Only Billing	A Medicare Part D co-payment only service was billed for a drug that is not covered by the Department.
B96	Compound has a Duplicate NDC	A claim was received for compound in which the same NDC appears twice. Please review compounding records and resubmit the claim with the correct ingredients.
B97	Duration of Therapy Exceeded	Patient has exceeded the recommended duration of therapy for the drug being billed. If the prescriber believes that it is appropriate to extend the therapy for the patient, the pharmacy can request a Refill-Too-Soon override using the Refill-Too-Soon Prior Approval Request Worksheet

Error Code	Message	Explanation
C01	NDC/Item Number not on File	A claim was submitted for a service, item or NDC which is not in the HFS reference database. Refer to provider records to verify the identification number or code for the service, item or NDC. If an incorrect number was submitted, rebill with the correct item number.
C02	Additional Information Required	Insufficient information was provided to process the claim for payment. If the claim was for a covered service, submit a new claim with a brief service description shown in the procedure description field. Also, attach the appropriate report (Operative, Radiology, Laboratory, Pathology, etc.). If no formal report is available, attach a typed narrative description of the service/procedure. If the claim was for a covered drug item, rebill showing the drug name/form/strength/quantity in the procedure/description field, or if additional space is required, the information may be attached to the claim.
C03	Illogical Quantity	Pharmacy billing: A Pharmacy service was submitted for a quantity less than the minimum allowed for the National Drug Code billed. If the quantity was entered incorrectly, rebill on a new claim with the correct information entered in the appropriate fields. If the quantity was billed correctly, contact the Pharmacy Prior Approval unit at 800-252-8942. All other billing: A claim was submitted for a service which does not require any entry in the Days/Units field of the claim form. Rebill and leave this field blank. If the procedure/service was performed more than once on the same date of service, use the corresponding “unlisted” code for the additional service(s). A description of the service(s) must be shown on the claim or an attachment.
C04	Pricing Review	The claim has been suspended for Department review. If no response is received within 30 days, review the claim to see if a description or attachment is needed. Rebill including the attachment. The final status of the service will be reported on a future Remittance Advice.

Error Code	Message	Explanation
C05	Maximum Quantity Limit Exceeded	The quantity billed exceeds the Department maximum. Payment was reduced to the Department's maximum allowable for the service billed. Do not rebill.
C06	NDC/Item Number Invalid on Date of Service	A claim was submitted with an NDC/item number which was not shown as a valid code on Department files on the date of service. If either the NDC/item number or the date of service was submitted incorrectly, rebill the service by submitting a new claim including the correct NDC/item number and date of service.
C07	Local Tax Available for Tuberculosis Treatment	A claim was submitted with a diagnosis code identified for tuberculosis treatment. The participant resides in a jurisdiction which levies a special tax for treatment of Tuberculosis. The local Department of Public Health office should be contacted for specific billing instructions. If funds are exhausted or if the county states they will only pay for certain services, contact an Institutional billing consultant for assistance.
C09	Psych Care Limited for Recipient Age	A claim was received from a psychiatric hospital for inpatient psychiatric services for a patient between the ages of 21 and 65. Inpatient psychiatric services provided by psychiatric hospitals are covered only for participants age 21 and younger (up to age 22 for those receiving services immediately prior to attaining age 21) and for participants age 65 and older. Review patient records for correct birth date. If the original claim contained incorrect information, a new claim may be submitted.
C10	Frequency Digit and Claim Type Indicator Disagree	An institutional claim was received with a Type of Bill 012X (Hospital Inpatient – Medicare Part B only) with a Medicare part A payment reported on the claim. Review and resubmit corrected claim.
C11	Non-Covered Days do not Balance with Dates	A claim was submitted and the number on non-covered days did not match the number of days reported in the non-covered occurrence span dates.

Error Code	Message	Explanation
C12	Item Number Miscoded	The eight-digit drug item code was not proper for the item described. If the description is correct for the prescribed item, the provider should rebill using the correct item number. If the description was incorrect for the item, the provider should rebill using the correct description.
C14	Item/Service not Allowed	One of three problems has occurred: 1) A claim was submitted for a drug not covered by the Department. Drugs not listed in the Drug Manual may be requested through Prior Approval. The following information is needed to facilitate the review of the request: Patient name and address; Recipient ID number; drug name (strength, dosage, quantity or package size); diagnosis or medical necessity; name, address and Provider Number of the prescribing practitioner; and, if available, the name and address of the dispensing pharmacist. Requests should be submitted to: Illinois Department of Healthcare and Family Services Attention: Drug Unit - Prior Approval Post Office Box 19117 Springfield, IL 62794-9117 Toll free: (800) 252-8942 AVRS: (800) 642-7588 Upon notification that Prior Approval has been granted, a new claim may be submitted by completing the entire service section; or 2) A claim was submitted for a medical supply or supplies not covered by the Department. Do not rebill; or 3) A claim was submitted for a service not allowed based upon the service description or due to another service billed for the same date. Do not rebill.
C15	Procedure not from ICD-9-CM (or upon implementation, ICD-10)	An adjustment was received with an invalid ICD-9-CM (or upon implementation, ICD-10) procedure code.

Error Code	Message	Explanation
C16	Procedure not Covered by IL Medical Assist	A claim was submitted for a procedure not covered by the Department's Medical Programs. Review the medical record. If an incorrect procedure code was reported, rebill using the correct code. If no error was made on the original claim, do not rebill. No payment can be made.
C17	Place of Service Illogical	NIPS billing: A claim was received for a procedure not normally performed in the reported setting. Determine whether the correct procedure code and correct place of service were reported. If incorrect, a new claim may be submitted with the correct information entered. If no error is detected but the provider feels the service was appropriate to the setting, submit a new claim with a letter explaining the appropriateness of the setting. Submit both in the Special Handling Envelope (HFS 2248). Institutional billing: A claim was submitted for a procedure not normally rendered in the reported hospital setting. Refer to medical records to determine if the correct procedure code was used.
C18	Abortion Form Invalid/Not Attached	A claim was submitted for abortion services. Either the required Form HFS 2390 (Abortion Payment Application) was not submitted or the form submitted was considered to be invalid. If the certification form was invalid, it will be returned with a copy of the claim and a letter specifying the rejection reason. If the form can be corrected or if the claim lacked the certification form, submit a new claim with the form attached. Submit both in the Special Handling Envelope (HFS 2248).
C19	Sterilization Form Invalid/ Not Attached	A claim was submitted for sterilization services. Either the required Form HFS 2189 (Consent Form) was not submitted or the form that was submitted was considered to be invalid. If the certification form was invalid, it will be returned with a copy of the claim and a letter specifying the rejection reason. If the form can be corrected or if the claim lacked the certification form, submit a new claim with the form attached. Submit both in a Special Handling Envelope (HFS 2248).

Error Code	Message	Explanation
C20	Diagnosis not from ICD-9-CM (or upon implementation, ICD-10)	A claim was submitted with a diagnosis code which is not in the ICD-9-CM Manual (or upon implementation, ICD-10). Refer to medical records to determine the correct diagnosis and then refer to the ICD-9-CM (or upon implementation, ICD-10) coding structure. If an incorrect code was reported, a new claim may be submitted with the correct code.
C21	Category of Service Requires Renal Revenue Code	An institutional claim was received on which the taxonomy code billed indicated Renal Dialysis, but there was not a covered renal dialysis revenue code on the claim.
C22	Emergency Charges not Valid for Clinics	An outpatient claim was received with a Revenue Code that was inappropriate for the Taxonomy Code billed. If an error was made, submit a corrected claim.
C23	Revenue Code Invalid for Category of Service	Review revenue codes to verify that they are valid for the Category of Service (UB-92 only) or Taxonomy Code (UB-04, 837I or Institutional DDE) billed. If an error was made, submit a corrected claim.
C26	Primary Diagnosis Info Required	A claim was submitted with no primary diagnosis. Review the medical record and submit a new claim which includes the patient's primary diagnosis code from the ICD-9-CM manual (or upon implementation, ICD-10).
C28	Missing HFS Payer	A claim submitted to HFS for payment consideration must have the payer (HFS) identified as Illinois Medicaid or 98916. HFS must be the payer of last resort.
C30	Invalid Payer Sequence	Illinois Medicaid must be reported as the last payer after any other third parties billed. Acceptable values are Illinois Medicaid or 98916.
C31	Procedure not on File for Date	A claim was received for a procedure code which is either an invalid code, not a valid code based on the service date, or a valid code which does not appear on Department files. The provider should refer to their records to determine whether the correct procedure code and date of service were reported. If an incorrect procedure or service date was reported, a new claim must be submitted with correct information. If the correct procedure code and date of service were billed, resubmit the claim with a letter identifying the source of the code used.

Error Code	Message	Explanation
C32	Procedure Illogical for Category of Service	A claim was submitted with a procedure code which is not appropriate for the taxonomy code allowed for the provider. If an incorrect procedure was submitted, rebill on a new claim using correct information.
C33	Procedure Illogical for Role	A claim was submitted with a type of service code (Field 23 E on HFS 2360 or Box 4 on the HFS 1443) which is inappropriate for the reported procedure. Submit a new claim which includes a type of service code appropriate to the procedure code.
C34	Provider Type not Allowed to Bill Dispensed Drugs	A claim was submitted with a charge for a dispensed drug but the provider is not enrolled as a physician. If an error was made in the Department's enrollment process, contact the Provider Participation Unit. Once the error has been corrected, rebill the service by completing a new claim form.
C35	TOS=Surgeon/ Modifier= Surgical Assistant	A claim was submitted for a surgical assist with incorrect values in field 23E (Type of Service) and in the Modifier area in field 24C. To bill for a surgical assist, the value in field 23E must be “8" and the modifier area in field 24C must be left blank. Submit a new claim with the correct information.
C47	Valid Accident/ Injury Code Required for Emergency Services	A claim was submitted with an emergency service procedure code, but the accident/injury code was either invalid or missing in the appropriate field/FL. A new claim may be submitted which includes an appropriate entry.
C48	Invalid Accident/ Injury Code Req	A claim was submitted with a procedure code for an Emergency Room visit and place of service of “E” (Emergency Room). However, the appropriate accident/ injury code was not used in the field 10B (Other). Review medical record to determine the correct billing information. Submit a new claim with the correct information.
C50	Review of Procedure/ Diagnosis Information	Do not rebill. The claim has been temporarily suspended for Department review. The final status of the claim will be reported on a future Remittance Advice.
C60	Diagnosis Code not Allowed	A service charge was submitted with Diagnosis Code 99999 (Diagnosis Not Listed). Submit a new claim with the specific diagnosis code.

Error Code	Message	Explanation
C61	Diagnosis/ Procedure not DRG Groupable	A claim was submitted with an illogical procedure and diagnosis combination, invalid 4th or 5th digit in the codes, or other ungroupable or invalid situations. Review the medical record for correct code assignment and submit a correct claim.
C63	Service not Covered as Billed	This error code can occur for two reasons: 1) An institutional claim for rehabilitation services has been received with a taxonomy code other than inpatient rehabilitation. A hospital must be enrolled for inpatient rehabilitation to be reimbursed for rehabilitation services. 2) A claim was received that grouped into DRG 436, which is not a valid DRG for hospitals.
C64	Admit Through Discharge Claim Required	All general inpatient (Inpatient Hospital services) claims from a DRG Hospital must be billed for the entire period covering admit through discharge. Submit a correct claim.
C68	Illogical Patient Status for Billing Status	Review Type of Bill Patient Discharge Status for conflicting information. (Example: Type of Bill indicates patient still hospital inpatient while Patient Discharge Status indicates patient was discharged.) Submit a correct claim.
C71	Anesthesia Unit Exceeds Department Maximum	The Department has a maximum limit for anesthesia services of 0480 minutes (8 hours). If the value in the Days/Units field exceeds this limit, the service will reject. Review to ensure that the total number of minutes was entered correctly (4 digit format). If the entry was incorrect, rebill on a new claim with the correct time. If the entry exceeds 0480 minutes, rebill on a new claim with a correct entry and attach a copy of the Anesthesia Record. Mail to the Department in the appropriate Special Handling Envelope (HFS 2248).

Error Code	Message	Explanation
C72	Minutes/Units Exceeds Department Maximum	The Department has a maximum time limit for Assistant Surgeon Services of 0480 minutes (8 hours). If the value in the Days/Units field exceeds this limit, the service will reject. Review a copy of the billing to ensure that the total number of minutes was entered correctly (4 digit format). If the value entered in the Days/Unit field was incorrect, rebill on a new claim with a correct entry in the Days/Unit field. If the entry in the Days/Unit field exceeds 0480 minutes, rebill on a new claim with the correct time and attach a copy of the Operative Report. Mail to the Department in the appropriate Special Handling Envelope (HFS 2248).
C75	No Principal Proc Code/ Data in Other Procedure Code	A claim was submitted with procedure code information in Other Procedure Codes and Dates but no principal procedure was reported in the Principal Procedure Code and Date field. Submit a correct claim with a valid procedure code from the ICD-9-CM manual (or upon implementation, ICD-10).
C78	Suspended for Prepay Review/ Procedure	Do not rebill. The claim has been temporarily suspended for Department review. The final status of the claim will be reported on a future Remittance Advice.
C81	Mixed Services/ Rebill Separately	A hospital provider cannot bill for physician services and Healthy Kids services on the same claim. Services should be separated and new claims submitted.
C84	Invalid Number of Tests/Procedure Code	The value shown in the Days/Units Field (HFS 2360, Field 24F) does not fall within the number of tests defined by the procedure code. The provider should review the copy of the claim to determine whether the service was miscoded. Rebill on a new Form HFS 2360 completing the entire service section with the correct data. If no error can be detected on the claim, complete a new claim and submit it with a brief explanation of the value entered in the days or units field.

Error Code	Message	Explanation
C86	Coinsurance and Deductible Illogical for Stay Less than 61 Days	A Medicare Crossover claim for less than 61 days has been received with an incorrect amount of coinsurance and deductible due. Review and submit a corrected claim.
C87	Suspend for Prepay Review/ Diagnosis	Do not rebill. The claim has been temporarily suspended for Department review. The final status of the claim will be reported on a future Remittance Advice.
C88	Prepay Review Rejection/ Diagnosis	The claim has been reviewed by the Peer Review Organization with one of the following results: • Chart was not available or case cancelled for review. Resubmit claim. • Partial denial of days.- submit a paper claim form to your medical consultant with a copy of the Advisory Notice from HSI. • DRG changes. Submit a paper claim form to your medical consultant with a copy of the Advisory Notice from HSI. • Full denial - Do not rebill.
C89	Not Payable Based on Medicare Determination	The claim submitted is non-payable by the Department based on the denial reason reported on Medicare's Explanation of Medicare Benefits. The provider may request reconsideration by the Medicare Carrier. If the claim was rejected in error, contact a billing consultant.
C90	Invalid Professional Fee	This error indicates that there is a problem with the pharmacy's records on the Department's Provider database. The provider should contact the Provider Participation Unit at 217-782-0538. Please indicate to staff that the error is related to the pharmacy's professional fee segment.
C91	Invalid Admit Date for Interim Claim	If the Type of Bill is either 0113 or 0114, The Admission Date must be the actual admission date and will never be the same as the From Date reported in the Statement Covers Period. Submit a correct claim. Note: DRG claims cannot be split.

Error Code	Message	Explanation
C92	Missing/ Invalid HCPCS for ER REV Code	Applies to outpatient claims only. If the date of service is prior to 07/01/04, and the claim contains revenue code 450 or 456, there must be at least one valid HCPCS code next to any revenue code (except 0001) on the claim. If the date of service is on or after 07/01/04, the emergency department revenue code must have a corresponding HCPCS code as identified in the Ambulatory Procedures Listing (APL) on the department's Web site.
C93	Department Will Reprocess Claim	Do not rebill. The Department will reprocess the claim.
C94	Review Charges and Submit Corrected Claim	Review charges and submit corrected claim.
C95	Procedure/ Service must be Billed on UB Invoice or 837I	This service was rejected because the hospital billed on a HFS 2360 claim form with a CPT IV procedure code for an APL service. Rebill on a claim form, 837I or Institutional DDE.
C97	No Payable Service on Claim/Rebill	A claim was received from a clinic with an encounter and corresponding detail service procedure codes. None of the detail service procedure codes listed are payable, therefore the encounter cannot be paid. Review the medical record. If an error is found in the detail procedure codes, rebill the encounter using the correct codes. If no error is found, do not rebill, as the encounter is not payable.
C98	More Specific Principal Diagnosis Code Required	A claim was received which contained a non-specific or an unspecified Principal Diagnosis Code. Review the patient's medical record and submit a correct claim.
C99	Prepay Review Rejection/ Procedure	The claim has been reviewed by the Peer Review Organization with one of the following results: -Chart was not available or case cancelled for review. Submit a new claim. -Partial denial - submit a paper claim form reflecting the review results outlined in the QIO Advisory Notice to your medical assistance consultant with a copy of the Advisory Notice. -Full denial - Do not rebill.

Error Code	Message	Explanation
D01	Duplicate Payment Voucher	NIPS: A claim was received which is a duplicate of one previously paid. Check the provider's payment records to verify that payment has been received. If no record of payment is found, contact a billing consultant. If the rejected procedure code was for a procedure or service, other than a lab test or x-ray, that was done more than once on the same date of service, rebill on a new claim using the appropriate corresponding "unlisted" procedure code. A brief description should be entered on the claim and an Operative Report (or narrative description) attached. Submit in a Special Handling Envelope, Form HFS 2248. UB Claim Form, 837I or Institutional DDE: A claim was received which was a duplicate of one previously paid to the billing facility or the claim overlaps a claim paid to another facility. If the paid voucher number given on the Remittance Advice cannot be identified by the billing facility, contact an UB billing consultant for assistance.
D02	Exceeds Daily Maximum Dose	Based on the quantity and days supply, the prescription exceeds the Department's calculated daily maximum dose. Review dispensing records to ensure that the correct quantity and days supply for the prescription were submitted. If incorrect values were submitted, resubmit the claim with corrected values. If the correct values were originally submitted, a prior approval requesting a daily maximum dose override must be submitted. The prior approval must contain clinical justification. The claim may be resubmitted if the daily maximum dose override is approved.
D03	Invoice does not Contain Provider Signature	Paper: The paper claim was submitted without a proper signature. Prepare and submit a properly signed claim. An original signature is required. Copies of signatures are not acceptable and will be rejected. Electronic: The electronic record was received with either a blank or an "N" in the Provider Signature field. A new record should be submitted with a "Y" in the Provider Signature field. Does not apply to UB-04 claims.

Error Code	Message	Explanation
D04	Suspended for Department Review	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.
D05	Submitted Later than One Year After Service	A claim was submitted more than twelve (12) months after the date on which the service was provided. Rebilled claims, as well as initial claims, received more than 12 months from the date of service will not be paid. See Chapter 100, Topic 112.
D06	Procedure Date Outside Per Diem Range	A claim was received on which the procedure date is not within the dates of service or the procedure date is the same as the discharge date but the procedure should be performed in an inpatient status. Review the medical record and Statement Covers Period; (Admission Date; Patient Status Code and procedure codes. Submit a correct claim.
D08	Claim Receipt Prior to Billing/ Service	The claim was submitted with a service date later than the billing date or the billing date is after the date of receipt by the Department. If the date of service or billing date was not correctly entered on the original claim, a new claim may be submitted.
D09	Accommodation Days not Equal Covered Days	An inpatient claim was received on which the value in Covered Days did not equal the sum of the service units listed for the Accommodation Revenue Code(s). Review the medical record to determine which value is correct. Submit a correct claim.
D10	Admission Date Greater Than Service Date	A claim was received on which the Admission Date billed on the claim is later than the From Date in the Statement Covers Period. Review the medical record to determine which date is correct. Submit a correct claim.
D15	Inpatient/ Outpatient Claims for Same Day	Department records indicate an inpatient claim was submitted for the same service date(s) as an outpatient claim was paid or vice versa. Contact a UB billing consultant at 1-877-782-5565 for assistance.
D17	Quantity Billed Requires Prior Approval	A claim was submitted for a quantity that exceeds the department's maximum allowed quantity. A quantity over the maximum allowed quantity requires prior approval. A prior approval request should be submitted for this service. After receiving prior approval, rebill on a new claim.

Error Code	Message	Explanation
D25	Undefined Error -- Contact Department	The claim was submitted with information which caused an unusual error condition. Contact a billing consultant at 1-877-782-5565 with details of the submitted claim for assistance.
D33	Inpatient or Group Care Claim	The claim contains one or more dates of service which were also contained on an inpatient or group care claim submitted by another provider. Contact a UB-92 billing consultant at 1-877-782-5565 for assistance.
D35	Prior Approved Total Dollar Amt Exceeded	The total dollar amount approved on the prior approval request form has been exceeded. No additional payment can be made under the existing prior approval.
D36	Prior Approved Total Quantity Exceeded	The quantity approved on the prior approval request form has been exceeded. No additional payment can be made under the existing prior approval. If additional quantities of the item or service are required, a new prior approval request must be submitted.
D37	Place of Service Requires Facility Name	The place of service code for this service requires entry of the facility name. Verify that the place of service code was correctly entered on the claim. If no error is found, submit a new claim with field 21 (Name and Address of Facility Where Service Rendered) completed.
D45	Submitted Later Than 2 Years After Service	A Medicare Crossover claim was submitted more than twenty-four (24) months after the date on which the service was provided. Medicare Crossover claims received more than twenty-four (24) months after the Date of Service will not be paid.
D50	Review of Submittal Information	Do not rebill. The claim has been temporarily suspended for Department review. The final status of the claim will be reported on a future Remittance Advice.
D74	Duplicate of Pending Claim	This service was processed and found to match another claim in payable status which has not yet been reported on a Remittance Advice. Do not rebill.
D77	Multiple Dates of Service on ERC Claim	A claim was submitted by an Encounter Rate Clinic showing more than one date of service. Each date of service requires its own claim. Submit new claims with only one date of service on each claim.

Error Code	Message	Explanation
D78	Optical Prescription Order Required	A claim was submitted for a Dispensing Fee, but no Optical Prescription Order (OPO) was attached. Submit a new claim for the Dispensing Fee and attach the OPO, with the prescription for the eyeglasses to be manufactured.
D80	Item has NDC/Rebill Pharmacy Claims System	A claim was submitted for an item that must be billed through the pharmacy system with an NDC. Rebill on NCPDP or a HFS 215 claim form.
D82	NDC Not Covered/ Mfgr not on File for Rebate	The Department can not pay for the requested NDC because the manufacturer is not enrolled in the Federal Rebate program.
D83	NDC Not Covered/ MFGR NOF for Rebate on DOS	The Department cannot pay for the requested NDC because the manufacturer was not enrolled in the Federal Rebate program on the Date of Service.
D88	NDC/Item Number not Approved on File	The claim was submitted with an NDC for which an error exists on the Department's NDC database. Please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance.
D89	NDC/Item Number not Priced on File	The claim was submitted with an NDC for which an error exists on the Department's NDC database. Please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, when this error is received.
D90	Manufacturer not on File for Rebate Quarter	The manufacturer of the NDC does not have a valid rebate agreement on file with the federal Centers for Medicare and Medicaid Services (CMS) on the date of service. The Department can only reimburse for drugs manufactured by companies who have signed rebate agreements with CMS. A listing of manufacturers with signed rebate agreements is available on the Department's Web site. If you have questions, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance.

Error Code	Message	Explanation
D91	Psychiatric Care not Approved as Billed	A claim containing a principal psychiatric diagnosis code has been received. A general care hospital not enrolled for inpatient psychiatric services may only bill for three emergency days as general inpatient care A hospital enrolled for inpatient psychiatric services must bill as inpatient psychiatric care. Review the Provider Taxonomy Code that was billed.

Error Code	Message	Explanation
E01	Missing Recipient Name	The claim was submitted with the Recipient Name field blank. The exact patient name must be entered in first, middle initial, last name format as shown on the Medical Programs Card. Rebill on a new claim.
E02	Missing Recipient Number	The claim was submitted with the Recipient Number field blank. Rebill on a new claim using the patient's nine digit Recipient Identification Number as shown on the Medical Programs Card.
E03	Invalid Recipient Number	The claim was submitted with either non-numeric characters in the recipient number field or more or less than nine (9) digits. Rebill on a new claim using the correct nine-digit Recipient Identification Number as shown on the Medical Programs Card.
E04	Missing Date of Service	The service section was submitted with the date of service field blank. Rebill on a new claim by completing the entire service section including the date of service entered in the MMDDYY format.
E05	Invalid Date of Service	The service section was submitted with a date of service format other than MMDDYY. Rebill on a new claim by completing the entire service section including the date of service entered in the MMDDYY format.
E06	Missing Prescription Number	Paper -The service section was submitted with the Prescription Number field blank. Refer to prescription file and rebill by completing the entire service section including the prescription number. Electronic -The service was received with blanks in the Prescription Number field. Review prescription file and enter prescription number in appropriate field when resubmitting.
E07	Missing NDC	NDC code was not submitted on the claim. For physician administered or dispensed drugs, the corresponding NDC code is required.
E08	Invalid NDC/ Item Number	The claim was submitted with an item number or NDC which is not found in the Department's file. The claim must be resubmitted with a valid item number or NDC.

Error Code	Message	Explanation
E09	Missing Quantity	NIPS: A claim was submitted with a type of service code which requires an entry in the Days/Units field. Rebill with a four-digit entry. When billing for anesthesia or surgical assistant services, enter the duration of time in minutes: e.g., the entry for 1 hour and 10 minutes is 0070. OASA: An OASA claim was submitted without the number of Service Units. Submit correct claim.
E10	Invalid Quantity	NIPS: A claim was submitted with non-numeric values in the Days/Units field. Rebill on a new claim with corrected four-digit entry in the Days/Units field. Pharmacy: A claim was received with non-numeric characters in the quantity field. Submit a new claim with numeric value in the quantity field.
E11	Missing Provider Number	The provider number field on a NIPS claim has been left blank. All services have been rejected. The Remittance Advice has been sent to the provider number on Department files which corresponds to the submitted provider name. If the provider who received the Remittance Advice did provide the service(s) billed, rebill on a new claim including the correct Provider Number.
E12	Invalid Provider Number	A claim was received on which the provider number field (on a NIPS claim) contained non-numeric characters or all zeros. All services have been rejected. The Remittance Advice has been sent to the provider number on Department files, which corresponds to the submitted provider name. If the provider who received the Remittance Advice did provide the service(s) billed, rebill on a new claim including the correct Provider Number.
E13	Missing Provider Name	The claim was submitted with the provider name field blank. All services have been rejected. The Remittance Advice has been sent to the provider name on Department files which corresponds to the submitted provider number. If the provider who received the Remittance Advice did provide the service(s) billed, rebill by completing a new claim including the correct provider name.

Error Code	Message	Explanation
E14	Repeat Following Deleted Service	A repeat indicator was entered in the service section immediately following a service section which was deleted. See the billing instructions in the Chapter 200 Appendices for proper use of repeat indicators. The entire service section must be rebilled on a new claim.
E15	Missing/Invalid Group Indicator	
E19	Missing Prescribing Practitioner No	The prescribing practitioner number field has been left blank. Rebill on a new claim by completing the entire section including the prescribing practitioner number.
E20	Invalid Prescribing Practitioner No	The prescribing practitioner number field has been completed with a number which is not a Drug Enforcement Administration (DEA) number or a Social Security Number (SSN). If the number was submitted incorrectly, rebill on a new claim form by completing the entire section including the correct prescribing practitioner number.
E21	Invalid Payee Code	The payee code submitted is not identified on the Department's records. Refer to Provider Information Sheet for correct payee indicator. Submit new correct claim. If the Payee information on the Provider Information Sheet is incorrect, contact the Provider Participation Unit.
E22	Invalid Category of Service	The claim was submitted with an invalid Category of Service code. Review Provider Information Sheet for the appropriate Category of Service code for the item/service being billed. Rebill using the appropriate Category of Service code.
E23	Invalid Type of Bill	A claim was received on which Type of Bill contained an invalid code. Submit correct claim.
E24	Missing/Invalid Patient Status	A claim was received on which the Patient Discharge Status contained an invalid code or was left blank. Review the patient records to determine the correct two-digit status indicator. Submit correct claim.
E27	Missing/Invalid Admission Date	An inpatient or hospice claim was received on which the Admission Date was left blank or contained an improperly entered date. Submit correct claim ensuring that the Admission Date is entered and in the correct format.
E28	Missing/Invalid Admission Hour	Inpatient claims only: Submit a corrected claim ensuring that the Admission Hour is entered and in a 2-digit format. Valid entries are from 00 through 23.

Error Code	Message	Explanation
E29	Invalid Through Date	Submit correct claim with the Statement Covers Through Date in the correct format.
E32	Missing/Invalid Newborn Birth Date	When Admission Type is 4 (newborn), Birth Date must be completed with the date of birth in a valid 8-digit format. Submit a correct claim.
E34	Missing/Invalid Procedure Date	An inpatient claim was received on which a procedure was indicated, but the corresponding date shown in conjunction with the Principal Procedure or Other Procedure Codes were not in the correct format. Submit a correct claim.
E35	Invalid Diagnosis Prefix	The claim was submitted with an invalid Primary Diagnosis Code prefix. Rebill by completing a new claim including the correct ICD-9-CM (or upon implementation ICD-10) diagnosis code. If the ICD-9-CM code (or upon implementation, ICD-10) contains a leading alpha character (either E or V) it must be included as part of the diagnosis code. Note: E-codes may not be used as a principal diagnosis.
E36	Missing/Invalid Diagnosis Code	A claim was submitted with either no code or an invalid code as the Principal Diagnosis Code or with an invalid code as one of the Other Diagnosis Codes. Review the medical record to determine the correct ICD-9-CM diagnosis code (or upon implementation, ICD-10). If the ICD-9-CM (or upon implementation, ICD-10) code contains a leading alpha character (either E or V) it must be included as part of the diagnosis code. E- codes may not be used as the Principal Diagnosis. Submit a new, corrected claim.
E37	Missing/Invalid Type of Admission	Admission Type code must be coded 1, 2, 3, 4, or 5 for inpatient claims.
E40	Family Planning Service Invalid for Age	The Procedure Code/Diagnosis Code received is not covered for the age of the participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
E45	Invalid HCPCS Code	Applies to outpatient claims with dates of service on and after 07/01/04. The claim has rejected because the HCPCS code on the claim is formatted incorrectly; or the code is not found on the department's database.
E47	Missing/Invalid Revenue Code	Submit a corrected claim with valid Revenue Code(s).
E48	Invalid Units of Service	Review Service Units. If an error is found, submit a new, corrected claim. If the units of service are correct, contact a billing consultant.

Error Code	Message	Explanation
E49	Missing/Invalid Accommodation Rate	Review HCPCS/Rates to determine if an accommodation rate was entered for each accommodation Revenue Code listed. Insert a decimal in the rate where indicated (e.g. 130.50). Submit a corrected claim. Hospice Billing: Review HCPCS/Rates to determine if a rate was entered for each revenue code except 657 (Physician services). Insert a decimal in the rate where indicated. Submit a corrected claim.
E52	Invalid Non-Covered Charges	Review a copy of the rejected claim to determine if the Non-Covered Charges are shown correctly. Submit a corrected claim.
E53	Missing/Invalid Total Charges	A claim was submitted with the Total Charge field either blank or containing non-numeric characters. Submit a correct claim including the Total Charge.
E54	Missing/Invalid Total Service Charge	Review Total Charges and Total Non-Covered Charges. Verify that the figures are valid. The total Covered Charges must be greater than the total Non-Covered Charges. Submit a corrected claim.
E55	Missing/Invalid Item or Procedure Code	NIPS: The claim was submitted with a missing or invalid procedure code or item in the service section. Review the medical record and rebill on a new claim including a valid procedure code. Institutional: The claim was submitted with a missing or invalid Principal Procedure code or Other Procedure Code(s). Review the medical record and submit a corrected claim with a valid ICD-9-CM (or upon implementation, ICD-10) procedure code.
E56	Missing/Invalid Non-Covered Days	The number of Non-Covered Days must be either blank or numeric.
E57	Invalid PSRO Approval Code	Review Condition Codes for PRO/UR approval indicator, to determine that a code was listed. Acceptable codes are C1 or C3. Submit a corrected claim.
E60	Invalid Spenddown Amount	A claim was received on which Value Code 66 (Medicaid Spenddown Amount), but the Value Code Amount is missing or invalid; or Value Code 66 is not present. Submit a correct claim with the HFS-2432 Split Billing Transmittal attached.
E63	Occurrence Span from Date Invalid	A claim was received on which the Occurrence Code 74 or 80, but the From Date is either missing or invalid. Submit a corrected claim.

Error Code	Message	Explanation
E64	Occurrence Span through Date Invalid	A claim was received on which the Occurrence Code 74 or 80, but the Through Date is either missing or invalid. Submit a corrected claim.
E65	Invalid Covered Days	The value submitted in Covered Days was a non-numeric value. Submit a corrected claim.
E68	Mothers Discharge Date Required/ Occ Code 53	If the admission date is prior to April 1, 2009, and the claim is paid based on per-diem logic, Occurrence Code 53 must be followed by the mother's discharge date. Submit a corrected claim.
E69	Missing/Invalid TPL Code	A claim was received with a missing or invalid Third Party Liability (TPL) code. Rebill on a new claim by completing the entire billing including a valid TPL code. The TPL code can be obtained from the participant's Medical Programs Card or from Chapter 100, General Appendix 9.
E70	Missing/Invalid TPL Status Code	A claim was received with a missing or non-numeric TPL Status Code. Rebill by completing a new claim with a valid TPL Status Code. Refer to billing instructions for specific types of claim forms.
E71	Missing/Invalid TPL Amount	TPL payment amount must be numeric.
E72	Valid Unit Required for Epogen	When Revenue Codes 634 or 635 are present, then Value Code "68" is required with the number of units listed. Submit a corrected claim.
E73	Missing/Invalid Total Deductions	A claim was received with either a blank or with non-numeric characters in the Total Deductions field. Rebill all services on a new claim with the correct value in the Total Deductions field.
E74	Missing/ Invalid Total Net Amount	A claim was received with either a blank or with non-numeric characters in the Net Amount field. Rebill all services on a new claim with the correct value in the Net Amount field.
E75	Missing/Invalid Billing Date	A claim was received with either a blank or an invalid billing date. Rebill on a new claim including the billing date in the MMDDYY format.
E78	Procedure Date not Equal Service Date	Principal Procedure and Other Procedure(s) code dates must be within the Statement Covers Period. Review the medical record to determine which date is in error, and submit a corrected claim.
E80	Invalid Units for Observation	Review Service Units to verify that the observation service units correspond to Revenue Code 762.

Error Code	Message	Explanation
E81	Occurrence Span From Date Greater Than Through Date	A claim was received on which the From date is later than the Through date for the Occurrence Span listed. The From date must be earlier than the Through date. Review the medical record to determine which date is incorrect. Submit a corrected claim.
E82	From Date Greater Than Through Date	A claim was received on which the From date is later than the Through date in the Statement Covers Period. The From date must be earlier than the Through date. Review the medical record to determine which date is incorrect. Submit a corrected claim.
E83	No Ancillary Revenue Code Identified	Unless the claim is for Skilled Care (hospital residing), Exceptional Care (hospital residing), DD/MI (hospital residing) or accommodation revenue code is 100, at least one ancillary (non-accommodation) revenue code must be present. Review the medical record and submit a corrected claim.
E84	Incorrect Covered Days	Review Type of Bill, Covered Days, Non-Covered Days and Patient Discharge Status for consistency. Contact a billing consultant if assistance is needed.
E85	Missing/Invalid Referring Practitioner Number	A claim was received with either a blank or with non-numeric characters in Field 19 (Provider Number). Rebill on a new claim including both the name and the Provider Number for the referring practitioner.
E86	Missing/Invalid From Date	ReviewStatement Covers Period-From Date. From date must be in valid format. Submit a corrected claim.
E88	Missing/Invalid Other Physician ID	Review Other Physicians ID. The claim was received with either a blank or invalid characters in the field. Submit a corrected claim with one of the following: -Social Security Number -AMA number - 1st 10 digits -Provider Number as assigned by the Department or -Unique Physician Identification Number (UPIN).
E89	No Covered Revenue Code Identified	Review Revenue Code(s). A covered revenue code is required in addition to revenue code 001. Review the medical record and submit a corrected claim.
E90	Missing Attending Practitioner Name	A claim was received with a value in Field 19 (Provider Name) but without the name of the attending practitioner or other source. Submit a new claim with the attending practitioner name.

Error Code	Message	Explanation
E91	Missing/Invalid Attending Physician Number	Review Attending Physicians ID. The claim was received with either a blank or invalid characters in the field. Submit a corrected claim with the Attending Physician's NPI.
E92	Missing Referring Practitioner Name	The claim was received with a value in Field 19 (Provider Name) but without the name of the referring physician or other source. Submit a new claim with the referring practitioner name.
E95	Missing/Invalid Renal Dialysis Place of Service	Review Condition Codes. For outpatient ESRD the applicable Renal Dialysis Setting Code must be entered. Valid values are 71, 72, 74, 75 and 76. Submit a corrected claim.
E97	Renal Dialysis Ancillary Charge not Shown	Review Revenue Code(s). When the Taxonomy Code is ESRD Treatment (Outpatient Renal Dialysis, ESRD), the claim must contain Renal Dialysis Revenue Code(s) that appropriately reflects outpatient renal dialysis service provided. Submit a corrected claim.
E98	Late Ancillary Claim Shows no Charges	When the Type of Bill frequency code is 5 the claim must contain Revenue Code(s) with charges greater than zero. Submit a corrected claim.

Error Code	Message	Explanation
F01	Payment Reduced	The charge was reduced to the Department's maximum allowable for the service billed. Do not rebill. If a billing error was made, the provider may submit an adjustment.
F02	Quantity Reduced to Department Maximum	The quantity billed was reduced to the Department's maximum allowable for calculation of the reimbursement amount. If no billing error occurred, do not rebill. If a billing error was made, the provider may submit an adjustment.
F04	Revenue Code 001 Total Recomputed	Review Total Charges and Non-Covered Charges. A claim was received with a total service charge which does not equal the sum of the individual charges. The Department has recomputed the charges. The provider records should be changed to reflect the correct total service charge.
F08	Recipient Name/Number has Been Corrected	Institutional: The claim was received with an incorrect Recipient Identification Number or Recipient Name. The Department was able to correct the error. The provider's records should be changed to reflect the correct information.
F09	Provider Name/Number Has Been Corrected	Institutional: The claim was submitted with a provider name that does not match the name to which the provider number is assigned. Review the current Provider Information Sheet for correctness of the provider name. Take appropriate action to ensure that all future claims submitted to the Department include entry of the correct provider name.
F11	Recipient Number Has Been Corrected	NIPS: The claim was received with an incorrect Recipient Identification Number. The Department was able to correct the error. The provider's records should be changed to reflect the correct Recipient Identification Number.
F12	Recipient Name Has Been Corrected	NIPS: The claim was received with an incorrect patient name. The Department was able to correct the error. The provider's records should be changed to reflect the correct patient name.
F13	Net Charge Recomputed	The claim was submitted with an incorrect net charge. Do not rebill. Informational message only.

Error Code	Message	Explanation
F15	Provider Name Has Been Corrected	NIPS: The claim was submitted with a provider name that does not match the name to which the provider number is assigned. Review the current Provider Information Sheet for correctness of the provider name. Take appropriate action to ensure that all future claims submitted to the Department include entry of the correct provider name. If the provider name on the Department's current Provider Information Sheet is not correct as shown, correct the name on the sheet, sign it and submit it to the Provider Participation Unit.
F16	Provider Number Has Been Corrected	NIPS: The claim was submitted with a Provider Number other than that carried on Department files for the Provider Name shown on the claim. Review the current Provider Information Sheet for correctness of the provider number. Take appropriate action to ensure that all future claims submitted to the Department include entry of the correct Provider Number.
F17	Third Party Source Not Identified	The claim was received with a third party liability amount however; the source of the TPL payment was not identified. The provider should ensure that future claims include entry of the TPL source.
F18	TPL Amount Greater Than Department Maximum	The claim was received showing an amount paid by a third party resource which exceeds the Department's maximum reimbursement for the service. If a billing error was made, the provider may submit an adjustment. If no error occurred, no action is required and no payment will be made.
F19	Payee Code Corrected	The claim was submitted with a payee code which did not correspond to information in Department files. The Department will report claims rejected for this error to the first active payee on the Department files. Future claims submitted should include the correct payee code. Refer to the Provider Information Sheet for a listing of the payees currently on file.
F20	Total Charges Recomputed	An inpatient claim was submitted with room and board total charges which do not equal the product of the room and board days times the room and board rate. The Department was able to correct the error. Provider records should be changed to reflect the correct room and board total charge.

Error Code	Message	Explanation
F21	Accommodation Total Recomputed	An inpatient claim was submitted with room and board total charges which do not equal the product of the room and board days times the room and board rate. The Department was able to correct the error. Provider records should be changed to reflect the correct room and board total charge.
F26	Total Deductions Recomputed	The sum of the individual TPL amount fields as entered on the claim do not equal the amount shown in Total Deductions field. If an error occurred in the original submittal, submit an adjustment. If no error occurred, no action is required.
F27	Service Date Format Corrected	A claim was submitted with an improper entry in the service date field. The provider should ensure that future claims include a service date in a 6-digit numeric MMDDYY format.
F28	Place Of Service Format Corrected	A claim was submitted with an improper entry in the place of service field. The provider should ensure that future claims include a place of service entry in a one-letter code format. See the Chapter 200 Billing Instructions for appropriate codes.
F29	Amount Format Corrected	A claim was submitted with entries for money amounts in an incorrect format. Example: 10 00. Ensure that future claims include entries for money amounts in a Dollars/Cents format.
F30	Number Of Sections Total In Error	A claim was received with an incorrect entry in the Total Service Sections field. The provider should ensure that future claims include a proper entry to reflect the total number of service sections completed on the claim. Do not include deleted sections. Optometrist: If this message appears but one or more services rejected, rebill the specific rejected services after making the necessary corrections to billing information. Do not attach a new OPO.
F36	Invalid Secondary Diagnosis	A claim was received with a secondary diagnosis code in an invalid format.
F39	Payment Reduced For Co-Payment	The Department has deducted the authorized patient co-payment from the total payment and paid the claim at the reduced amount.

Error Code	Message	Explanation
F44	Spenddown Not Applied/ QMB Recipient	A claim was received with a TPL code of 906 (Spenddown) in the TPL Code field. The patient is a Qualified Medicare Beneficiary (QMB). Application of Spenddown is inappropriate. Bill Medicare for adjudication of the service before billing Medicaid.
F47	Newborn Payment	Hospital inpatient claim paid based on newborn payment methodology.
F49	Invalid Payment Date	A claim was received with a payment date that was not numeric or the payment date was prior to the date of service.
F52	Eyeglasses Fabricated	A claim was submitted for a dispensing fee. This message is to notify the optical provider that eyeglasses will be fabricated by the Department of Corrections and mailed to the optical provider for dispensing to the participant. If the dispensing fee claim was approved and paid, do not rebill; informational message only. If the dispensing fee claim was rejected, review the error codes that caused the rejection and submit a new, corrected claim. Mail the claim to the attention of the billing consultant. Do not submit a new OPO.
F53	Eyeglasses Not Fabricated	This claim was submitted for a dispensing fee but rejected because of errors or omissions in the patient eligibility fields of the claim. This message is to notify the optical provider that eyeglasses will not be fabricated by the Department of Corrections until a new, corrected claim has been submitted and adjudicated. Review the patient files and rebill on a new claim, with careful attention to the patient name and Recipient Identification Number. Important: A new OPO must be attached to the rebilled claim.
F54	Eyeglasses Not Fabricated Exceeds Limit	A claim was submitted for a dispensing fee. This message is to notify the optical provider that eyeglasses have not been fabricated by the Department of Corrections. Eyeglasses were previously fabricated by the Department of Corrections and dispensed within the 2-year limit for adults.

Error Code	Message	Explanation
F55	Replacement Part Authorized	A claim was submitted for a service fee. This message is to notify the optical provider that a replacement part has been authorized and the Department of Corrections will be mailing the part to the optical provider. Do not rebill; informational message only.
F56	Replacement Part Not Authorized	A claim was submitted for a service fee but rejected because of errors or omissions in the patient eligibility fields of the claim. This message is to notify the optical provider that a replacement part has not been authorized and the Department of Corrections will not be mailing the part to the optical provider until a new, correct claim has been received and adjudicated. Review the patient files and rebill on a new claim, with careful attention to the patient name and Recipient Identification Number.
F63	Suspended For Emergency Review	Do not rebill. The claim has been temporarily suspended for Department review. The final status of the claim will be reported on a future Remittance Advice.
F68	NDC Obsolete/ Check Obsolete Date	The NDC submitted for this service has been obsolete for a period equal to or greater than three years from the Date of Service. Review the dispensing records and submit a new claim with the correct NDC.
F70	Payment Based On DRG XXX	Reimbursement has been issued based on the Department's Diagnosis Related Group Prospective Payment System. This message notifies the provider of the particular DRG upon which payment is based.
F72	Invl/Missing CLIA Cert For Date Of Service	A claim was received and there was no CLIA Certificate on file, or the CLIA Certificate was expired for the Date of Service, or the services billed are not covered under the CLIA Certificate on file for the Date(s) of Service. Check to see if the service being billed is allowed for the CLIA Certificate on file. Correct claim, then rebill. If no certificate is on file, submit the CLIA Certificate to the Provider Participation Unit to update the Department’s Provider file.

Error Code	Message	Explanation
F76	Suspended For Pre-Pay Review/ Newborn	The claim has been temporarily suspended for Department review. Do not rebill. The final status of this claim will be reported on a future Remittance Advice.
F77	Suspended For DRG Reassignment/ Review	The claim has been temporarily suspended for Department review. Do not rebill. The final status of this claim will be reported on a future Remittance Advice.
F78	Suspended For Prepay Review	The claim has been temporarily suspended for Department review. Do not rebill. The final status of the claim will be reported on a future Remittance Advice.
F84	Expired License Submit Proof Of Renewal	A claim was received from a provider whose license number had expired for the date of service being billed.
F85	Medical License Expired	A claim was received for a provider whose license has expired. Contact the Department's Provider Participation Unit. Contact Provider Participation Unit at 217-782-0538.
F89	Service Must Be Billed Through CBO	A claim was received for a participant in the Early Intervention (EI) Program. These services must be billed through the EI Central Billing Office (CBO). Contact the EI CBO at 1-800-634-8540.
F94	Payment Reduced To HFS Allowable For Visit	The charge received exceeded the Department's maximum allowable rate for the visit billed. The payment rendered is the maximum allowed for the procedure code submitted.
F96	X-Ray Procedure Reduced To HFS Allowable	The charge received exceeded the Department's maximum allowable rate for combination x-rays. Review the patient's medical record with the CPT-4 definition of the procedure code entered on the original claim. If a separate x-ray procedure or an unusually large number of x-ray procedures were required because of the nature of the patient's injury or illness, the provider may seek payment reconsideration by submitting a properly completed Adjustment. The Adjustment must be accompanied by documentation supporting the medical need.
F97	Lab Procedure Reduced To HFS Allowable	Two or more Lab procedures were received which are components of a complete Lab procedure. Payment has been reduced on this procedure so that payment for the individual procedures does not exceed the maximum allowable rate for the complete Lab procedure.

Error Code	Message	Explanation
F99	Pmt Reduced To HFS Allowable For Service	The charge received exceeded the Department's maximum allowable rate for the service billed. The payment returned is the maximum allowed for the procedure code submitted.

Error Code	Message	Explanation
G10	Payee Must Be Medical School	A claim was received for group psychotherapy services rendered by a resident and the school of medicine was not listed as the payee. Group psychotherapy claims submitted on the behalf of a resident must have the school of medicine listed as the payee. Review the medical records and the coding on the rejected claim for correctness. If an error is found, submit a correct claim. If all information was correct on the original claim, do not rebill.
G11	IHC PCP Referral Required	A claim was submitted for a service, which requires a referral from the participant's Illinois Health Connect (IHC) primary care provider (PCP), but no referral is posted on the Department's files. A referral from the IHC PCP should be submitted for this service within 60 days of the date of service. After receiving a referral, rebill the service on a new claim. For help in submitting a referral or if there are questions about the referral system, please contact the Illinois Health Connect Provider Helpdesk at 1-877-912-1999.
G33	Missing/Invalid Qualifier	**UB-04 Claims Only** - A claim was received with an NPI entry in FL 78 or 79 and the Provider Type Qualifier Code was missing or invalid. If an NPI is reported in FL 78 or 79 a two-digit Provider Type Qualifier Code must be reported. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
G39	Recipient In MCO – Integrated Care	Department records reflect that the participant was enrolled in the Integrated Care Program (ICP) on the date of service. ICP is administered through two managed care organizations, Aetna Better Health and IlliniCare Health Plan. Contact the appropriate plan for billing information.
G50	Chiropractic Service Inappropriate for Diagnosis	A claim was received for chiropractic services which contained an inappropriate diagnosis. Chiropractic services are limited to spinal manipulation procedures to correct subluxations of the spine. Review the claim and if an error was made on the diagnosis, rebill. If no error was made on the original claim, do not rebill. No payment can be made.

Error Code	Message	Explanation
G51	Podiatric Service Inappropriate for Diagnosis	A claim was received for podiatric services which did not contain a primary diagnosis of diabetes. Podiatric services are limited to adults with diabetes. Review the claim and if an error was made on the diagnosis, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
G52	Hospice Inappropriate Bill	A claim was received for a service provided to a participant who is receiving hospice services. Additional services are not allowed. Do not rebill. No payment can be made.
G54	Group Psychotherapy not Allowed for LTC	A claim was received for a service that is not covered for participants who are residents in a nursing facility, including a nursing facility classified as an institution for mental diseases, or a facility licensed under the Specialized Mental Health Rehabilitation Act. Do not rebill. No payment can be made.
G79	Prov Authorization For DMH Legacy Only	Provider not eligible to bill Medicaid services.
G80	DMH FY Contract Not On File	Provider contract information has not been received by HFS. Contact VO.
G81	DMH Provider Registration Not On File	Authorization code is not on HFS provider database. Contact VO.
G82	Recipient DMH Blanket Authorization Not Found	No authorization is found for the client for the service billed.

Error Code	Message	Explanation
G83	Recipient Service Class Authorization Not Found	DOS is on or after 7/1/11 and the recipient has an authorization for the service package but not an authorization for the service class.
G84	Recipient Service Quantity Exceeded	The authorization on HFS file has been exceeded. Contact VO.
G85	No Usable Funds Auth For Recip/Prov Combination	HFS is not able to find an authorization on file for this provider and recipient for the date of service.
G87	Missing DHS Allowed Amt (Spec Elig) Code	The client's OBRA code has not been received from DMH/VO. Therefore, the percentage to pay on the claim is unknown until the OBRA information is received.
G88	Exceeds Service Package Limits	Authorized service package limits have been exceeded. VO may be contacted to authorize additional services.
G89	Procedure/Modifier Combo Not Utilized	Procedure/Modifier combination billed cannot be found in any benefit package on the DMH benefit table.
G90	Prior Auth Not Allowed For Recipient Age	A claim was received for a date of service after 6/30/10. The client was authorized for a benefit package or service class that is inappropriate for the client's age.
G91	Proc/Mod Combo Not Incl In Prov Authorization	A claim was received for a date of service after 6/30/10. The recipient has the benefit package authorization on file for the date of service but the procedure/modifier combination is not found on the provider's accumulator file.
G98	Psychiatric Residency Not On File	A claim was received for a provider who does not have proof of completion of a psychiatric residency or certification in Psychiatric and Mental Health Nursing on file with the Department. If the provider of service is a psychiatrist who has completed a psychiatric residency or a psychiatric APN who holds the appropriate certification, please contact the Provider Participation Unit at 217-782-0538 to obtain the necessary forms needed to update the provider file. If the provider does not hold the appropriate certification, they cannot bill for the services.

Error Code	Message	Explanation
G99	Diagnosis Not Psychiatric	A claim was received for group psychotherapy and the diagnosis code was not a valid ICD-9-CM (or upon implementation, ICD-10) diagnosis within code range 290 through 319. Review the medical records and the coding on the rejected claim for accuracy. If an error is found, submit a correct claim. If all information was correct on the original claim, do not rebill.

Error Code	Message	Explanation
H01	No DHS Service Segment	A claim was received for a participant who does not have active eligibility for DHS services. Contact the DHS RIN Unit at 1-800-385-0872.
H02	Recipient In SASS Program	A claim was submitted to DHS for a participant in the SASS Program. Resubmit the claim to HFS.
H03	Recipient Not Eligible For Service	This error code was generated in error and should not appear in future for community mental health provider claims.
H04	DHS Segment Missing For Non MRO Service	Services billed are DHS Social Services program covered services and client does not have DHS Social Service eligibility. Contact the DHS RIN Unit at 1-800-385-0872.
H05	Service Not Covered-Recip IDOC/IDJJ	A claim has been received for a participant who is an IDOC/IDJJ inmate, which is identified with a Local Office code of 195. Any service **not** performed in the inpatient, outpatient, or emergency room setting must be billed to the IDOC or IDJJ medical vendor for adjudication. Providers may contact HFS at 217-782-3541 for IDOC/IDJJ medical vendor information.
H16	Missing/Invalid NDC	NDC code was not submitted on the claim or is invalid. For physician administered or dispensed drugs, the corresponding NDC code is required.
H20	Provider NPI Required	A claim was received by HFS on or after 5/23/08 and there was no NPI reported on the claim.
H23	Inelig For Payment-No Rebate Rate Segment	
H26	Missing/Invalid Billing/Creation Date	The creation date (UB-04) is missing or not reported in the correct format. Review and submit a corrected claim.
H29	Missing Value Code For Covered Days	UB-04 claims only: Value Code 80 for covered days is missing.
H30	Missing/Invalid Amount For Value Code Covered Days	UB-04 claims only: The amount field associated with Value Code 80 (covered days) is blank, zero, or non-numeric. The number of covered days is to be reported right justified to the left of the dollars/cents delimiter.

Error Code	Message	Explanation
H31	Missing/Invalid Value Code For Non-Covered Days	UB-04 claims only: If the claim contains Condition Code C3 and Value Code 81 (non-covered days) is missing or Value Code 81 is present but associated amount is blank or zero. If the claim contains Occurrence Span Code 74 or 80 and Value Code 81 is missing or Value Code 81 is present but associated amount is blank or zero. The number of non-covered days is to be reported right justified to the left of the dollars/cents delimiter.
H34	Missing/Invalid Value Code For Covered Days Series Claim	UB-04 claims only: Series claims require the number of treatment days to be reported in covered days. Value Code 80 and amount for covered days is missing or invalid. The number of covered days is to be reported right justified to the left of the dollars/cents delimiter.
H38	Not Covered By Mental Health	Procedure code billed is not covered by Community Mental Health Services program. Verify code billed.
H39	Billing Provider NPI Not Registered	A claim was received by HFS on or after 5/23/08 and the claim contained a NPI that was not registered on the department's database.
H42	NPI Not Useable	A claim was received by HFS on or after 5/23/08 and the claim contained a NPI that could not be crosswalked to a HFS Provider Number.
H43	Missing/Invalid Attending NPI	A claim was received by HFS on or after 10/1/08 with an invalid NPI or the NPI was not reported for the Attending Physician, which is required on all claims except for outpatient renal dialysis services.
H44	Missing/Invalid Operating NPI	A claim was received by HFS on or after 10/1/08 with an invalid NPI or the NPI was not reported for the Operating Physician, which is required on all inpatient claims, general outpatient, and outpatient physical rehabilitation services, if a surgical procedure is performed.
H45	Missing/Invalid Other Physician NPI	A claim was received with the "ZZ" Other Operating Physician Qualifier Code, but the corresponding NPI is invalid or missing. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
H48	Rendering NPI Invalid	A claim was received by HFS on or after 3/23/09 and the claim contained a Rendering Provider NPI that was invalid.

Error Code	Message	Explanation
H49	Payee NPI Not Valid	A claim was received by HFS on or after 3/23/09 and the claim contained a Payee NPI that was invalid. Effective March 30, 2009, this error message is inactive.
H50	Payee Not Valid For Provider	A claim was received by HFS and the claim contained a Payee NPI that was crosswalked to a 16-digit payee number and that payee number was not valid or active on the provider file.
H55	Missing/Invalid Rendering Provider NPI	A claim was received with the “82” Rendering Provider Type Qualifier Code, but the corresponding NPI is invalid or missing. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
H56	Missing/Invalid Referring Provider NPI	A claim was received with the “DN” Provider Type Qualifier Code, but the corresponding NPI is invalid or missing. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
H84	DMH/VO Processing Incomplete	Claim on hold until DMH/VO completes processing all claims submitted through VO for DOS prior to 7/1/11.
H85	DMH/VO Processing Incomplete	Claims with DOS greater than 6/30/11 are on hold by HFS until claims submitted through DMH/VO have completed processing. Do not rebill.
H87	DMH FY Contract Not On File	Pending contract information from DMH. Do not rebill.

Error Code	Message	Explanation
I05	AllKids Payment Reduced Copay/Coinsurance*	Institutional: The Department has deducted the authorized patient co-pay/coinsurance from the total payment and paid the claim at the reduced amount.
I07	Veterans Payment Reduced Copay/Coinsurance*	Institutional: The Department has deducted the authorized patient co-pay/coinsurance from the total payment and paid the claim at the reduced amount.
I30	Rendering NPI Missing/Invalid	A claim was received on or after 3/23/09 and the Rendering Provider NPI was missing or invalid. Do not rebill; informational message only.

Error Code	Message	Explanation
K01	Limit 2 Group Psych Visits In 7 Days	A claim for a group psychotherapy service was billed for a participant that exceeds the Department's limit of two (2) sessions in a seven (7) day period. Review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim. If an error is found, submit a correct claim. If all information was correct on the original claim, do not rebill.

Error Code	Message	Explanation
M18	Missing Purchase/ Rental Code	A service section was received with the Purchase/Rental field blank. Submit a new claim with the Purchase/Rental field completed with a valid value.
M20	Missing Origin/ Destination Place Code	A service section was received with either the Origin Place or Destination Place field blank. Submit a new claim with both the Origin Place and Destination Place fields completed with valid values.
M22	Missing/ Invalid Category Of Service	A service section was received with either blanks or non-numeric values in the Category of Service field. Submit a new claim, completing the entire service section, including the appropriate category of service coding. See Provider Information Sheet for allowable Categories of Service.
M23	Missing Type Of Bill	A claim was received with the Type of Bill field blank. Submit a corrected claim.
M24	Missing Patient Status	A claim was received without a valid entry in Patient Discharge Status. Patient status must be present for both inpatient and hospice claims. Submit a corrected claim.
M27	Missing Admission Date	The claim was received with the Admission Date field blank. This field is required for inpatient and hospice claims. Submit a corrected claim.
M28	Missing Admission Hour	The claim was received with the Admission Hour field blank. This field is required for inpatient claims. Submit a corrected claim ensuring that hour shown is in a 2-digit format. Valid entries are from 00 through 23.
M29	Missing Thru Date	Review Statement Covers Period. The claim was received with blanks in the Through field. This field is required for all inpatient and OASA claims. Submit a corrected claim.
M31	Newborn Occurrence Code Required	If the claim is for newborn charges and the Admit Date is equal to the infant's Birth Date the claim must have either Occurrence Code 53 or 58. Occurrence Code 53 also requires the mothers discharge date. Submit a corrected claim.
M32	Missing Newborn Birth Date	If Admission Type contains code 4 (Newborn), the newborns Birthdate must be completed. Submit a corrected claim.

Error Code	Message	Explanation
M36	Missing Diagnosis Code	A claim was received with no Principal Diagnosis Code. Review the medical records to determine the appropriate principal diagnosis code from ICD-9-CM (or upon implementation, ICD-10) (including prefix, if required) and submit a corrected claim. Note: E-codes are not acceptable as the principal diagnosis code.
M37	Missing Type Of Admission	Review Admission Type. Admission Type must be coded 1, 2, 3, 4 or 5 for inpatient claims. Submit a corrected claim.
M44	Missing/Invalid Procedure Code/Date	Inpatient and OASA Claims: If a procedure code is present, a corresponding date must be entered. If a date is present, a procedure code must be present. OASA claims with dates of service on or after July 1, 2005: For each HCPCS code there must be a corresponding service date. Submit a corrected claim.
M47	Missing Accommodation Code	Review Revenue Code. A valid room and board revenue code must be shown for an inpatient claim. Submit a corrected claim.
M48	Missing Units Of Service	Hospital Billing: Review Service Units. For the accommodation code for inpatient claims, the number of days must be entered as Service Units. If all days associated with an accommodation code are being reported as non-covered days, a numeric zero must be entered for the units. Submit a correct claim. For outpatient series claims, series billable revenue codes must have service units greater that zero. Hospice Billing: Review Service Units. For revenue codes 651, 655, 656, and 658, the number of days is entered as Service Units. For revenue code 652, the number of hours is entered as Service Units for dates of service prior to January 01, 2007 and for dates of service on or after January 01, 2007 the number of Service Units is entered as 15 minute increments. For revenue code 657, the number of visits or procedures is entered as Service Units. Submit a corrected claim.
M49	Missing Accommodation Rate	Review Revenue Code and HCPCS / Rates to determine whether an accommodation rate was entered for each accommodation listed. Insert a decimal where indicated (e.g.130.50). Submit a corrected claim.

Error Code	Message	Explanation
M50	Missing Charge	Revenue Code(s) and Total Charges. An entry must be made for Total Charge for each revenue code. Submit a corrected claim.
M51	Missing Revenue Line For Total Charge 0001	Review Revenue Code. Revenue code 0001 for total charges was missing on the claim. Submit a corrected claim.
M53	Missing Total Charges	A claim was received with the Total Charges field blank. Submit a new claim with a value in the Total Charges field.
M55	Missing Procedure Code /Drug Code	NIPS: The claim received was missing either the Procedure Code or Drug Item number in the Item or Procedure Code field. Submit a new claim with a valid value in either the Item or Procedure Code field as appropriate. Institutional: Review Revenue Code and Principal Procedure through Other Procedure. For inpatient claims, if an operating room revenue code is present, must contain a corresponding procedure code. For outpatient claims, if the Provider Taxonomy Code billed is other than Outpatient Renal Dialysis, an APL procedure code must be present. For OASA claims, a procedure code must be present. Submit a corrected claim.
M56	Missing Non-Covered Days	If the claim contains Occurrence Span Code 74 or 80, then the claim must contain the number of Non-Covered Days. Submit a corrected claim.
M63	Missing Occurrence Span From Date	If the Occurrence Code value contains the span code of 74 or 80, then the From date must be present in MMDDYY format. Submit a corrected claim.
M64	Missing Occurrence Span Through Date	If the Occurrence Code value contains the span code of 74 or 80, then the Through date must be present in MMDDYY format. Submit a corrected claim.
M65	Missing Covered Days	Review Covered Days. The number of Covered Days must be entered on all inpatient, hospice and outpatient series claims. Submit a correct claim.
M68	Mother's Discharge Date Required/OCC Cd 53	Review Occurrence Code and date. Occurrence code 53 must be followed by the mother's discharge date.

Error Code	Message	Explanation
M69	Missing Third Party Source	Institutional: Review Prior Payments. If a TPL payment amount is present, the two digit TPL source code must be present. Refer to General Appendix 9 for a listing of TPL source codes. Paper claims submitted on or after May 01, 2008 must be billed on the UB. NIPS: Review the TPL Code field in either the service section or at the bottom of the claim form. An entry in any of the other TPL data fields requires a valid value in this field. Refer to General Appendix 9 for a listing of TPL source codes. Submit a new claim with correct data.
M70	Missing TPL Status Code	Institutional: If a TPL Source Code is present a TPL Status Code must be entered. Submit a correct claim. NIPS: Review the Status field in either the service section or at the bottom of the claim form. An entry in the TPL Code field requires a valid value in this field. Refer to billing instructions in the Chapter 200 Appendices of the applicable provider handbook for valid values for this field. Submit a new claim with correct data.
M71	Missing TPL Amount	Institutional: Review Prior Payment information. If TPL information indicates a valid TPL Status Code of 01, 08 or 09, then the TPL payment amount must be entered and must be greater than zero for all claims. For TPL Status Code 99 (Medicare/Medicaid crossover claim only) the TPL payment amount must be entered and must be numeric. Submit a corrected claim. NIPS: Refer to billing instructions in the Chapter 200 Appendices of the applicable provider handbook for the TPL status codes that require an entry in this field. Submit a new claim with correct data.
M72	Missing/Invalid TPL Date	Institutional 837I and DDE: TPL prior payment Claim Adjudication Date required.
M75	Bill Date Missing	A claim was received with blanks in the Billing Date. Submit a correct claim with the Billing Date entered in the MMDDYY format.

Error Code	Message	Explanation
M77	Missing/Invalid Vehicle License Number	A transportation claim was received and the vehicle license number was not reported or the license number was invalid.
M81	Missing Non-Covered Occurrence Span Code	If the claim contains Non-covered Days, then the claim must contain Occurrence Span Code 74 or 80 with the non-covered date span. Submit a corrected claim.
M85	Miss Ref Prac Nbr	A claim was received for a service which required the Referring Practitioner Number be reported.
M87	Missing From Date	Review Statement Covers Period. The From date must be present. Submit a corrected claim.
M91	Missing Attending Physician Number	Review Attending Physician. The attending physician identification number must be entered for all claims except when the Taxonomy Code billed is ESRD Treatment (Outpatient Renal Dialysis, ESRD). Submit a corrected claim.
M93	Missing Payee/Multiple Payees	No payee was identified on the claim form. Department records indicate multiple payees for the provider. Submit a new claim form including the appropriate payee number from the Provider Information Sheet. If the payee information reflected on the Provider Information Sheet is incorrect or out of date, contact the Department's Provider Participation Unit Provider Participation Unit at 217-782-0538.

Error Code	Message	Explanation
N01	Invalid 1st diagnosis code	A claim was submitted with an invalid code as the primary diagnosis code. Review the medical record to determine the correct ICD-9-CM (or upon implementation, ICD-10) diagnosis code. If the ICD-9-CM (or upon implementation, ICD-10) code contains a leading alpha character (either E or V) it must be included as part of the diagnosis code. E-codes may not be used as the primary diagnosis. If an incorrect code was reported, a new claim may be submitted with the correct code.
N02	Invalid 2nd diagnosis code	A claim was submitted with an invalid code as the secondary diagnosis code. Review the medical record to determine the correct ICD-9-CM (or upon implementation, ICD-10) diagnosis code. If the ICD-9-CM (or upon implementation, ICD-10)code contains a leading alpha character (either E or V) it must be included as part of the diagnosis code. If an incorrect code was reported, a new claim may be submitted with the correct code.
N03	Invalid 3d diagnosis code	A claim was submitted with an invalid code as the third diagnosis code. Review the medical record to determine the correct ICD-9-CM (or upon implementation, ICD-10) diagnosis code. If the ICD-9-CM (or upon implementation, ICD-10) code contains a leading alpha character (either E or V) it must be included as part of the diagnosis code. If an incorrect code was reported, a new claim may be submitted with the correct code.
N04	Invalid 4th diagnosis code	A claim was submitted with an invalid code as the fourth diagnosis code. Review the medical record to determine the correct ICD-9-CM (or upon implementation, ICD-10) diagnosis code. If the ICD-9-CM (or upon implementation, ICD-10) code contains a leading alpha character (either E or V) it must be included as part of the diagnosis code. If an incorrect code was reported, a new claim may be submitted with the correct code.
N05	1st diagnosis not from ICD9 (or upon implementation ICD-10)	A claim was submitted with a primary diagnosis code which is not in the ICD-9-CM (or upon implementation, ICD-10) Manual. Refer to medical records to determine the correct diagnosis and then refer to the ICD-9-CM (or upon implementation, ICD-10) coding structure. If an incorrect code was reported, a new claim may be submitted with the correct code.
N06	2nd diagnosis not from ICD9 (or upon implementation ICD-10)	A claim was submitted with a secondary diagnosis code which is not in the ICD-9-CM (or upon implementation, ICD-10) Manual. Refer to medical records to determine the correct diagnosis and then refer to the ICD-9-CM (or upon implementation, ICD-10) coding structure. If an incorrect code was reported, a new claim may be submitted with the correct code.

Error Code	Message	Explanation
N07	3d diagnosis not from ICD9 (or upon implementation, ICD-10)	A claim was submitted with a third diagnosis code which is not in the ICD-9-CM (or upon implementation, ICD-10) Manual. Refer to medical records to determine the correct diagnosis and then refer to the ICD-9-CM (or upon implementation, ICD-10) coding structure. If an incorrect code was reported, a new claim may be submitted with the correct code.
N08	4th diagnosis not from ICD9 (or upon implementation, ICD-10)	A claim was submitted with a fourth diagnosis code which is not in the ICD-9-CM (or upon implementation, ICD-10) Manual. Refer to medical records to determine the correct diagnosis and then refer to the ICD-9-CM (or upon implementation, ICD-10) coding structure. If an incorrect code was reported, a new claim may be submitted with the correct code.
N09	1st diagnosis invalid for date of service	The diagnosis code received is not covered for the date of service. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N10	2nd diagnosis invalid for date of service	The diagnosis code received is not covered for the date of service. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N11	3d diagnosis invalid for date of service	The diagnosis code received is not covered for the date of service. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N12	4th diagnosis invalid for date of service	The diagnosis code received is not covered for the date of service. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N13	1st diagnosis invalid for recipient age	The diagnosis code received is not covered for the age of the participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.

Error Code	Message	Explanation
N14	2nd diagnosis invalid for recipient age	The diagnosis code received is not covered for the age of the participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N15	3d diagnosis invalid for recipient age	The diagnosis code received is not covered for the age of the participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N16	4th diagnosis invalid for recipient age	The diagnosis code received is not covered for the age of the participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N17	1st diagnosis invalid for recipient sex	The diagnosis code received is not covered for the gender of the participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N18	2nd diagnosis invalid for recipient sex	The diagnosis code received is not covered for the gender of the participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N19	3d diagnosis invalid for recipient sex	The diagnosis code received is not covered for the gender of the participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
N20	4th diagnosis invalid for recipient sex	The diagnosis code received is not covered for the gender of the participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.

Error Code	Message	Explanation
P01	Provider Not Eligible For Category Of Service	UB-04, 837I and Institutional DDE: The provider taxonomy code for which the provider billed is not one for which they are eligible based on the assigned provider type. Refer to the Provider Information Sheet for allowable Categories of Service for the Provider Number. Verify if the appropriate corresponding provider taxonomy code was billed.
P02	Provider Not Enrolled For Category Of Service	A claim was received showing a Category of Service for which the provider has never been enrolled. Contact the Department's Provider Participation Unit Provider Participation Unit at 217-782-0538.
P03	Provider Not Enrolled For Cos/Date Of Service	A claim was received for a date of service which is either before the begin date of the provider's enrollment or after the termination of the provider's participation for the applicable Category of Service according to the Provider Information Sheet. Review the DOS, correct if necessary and resubmit; or review Provider Information Sheet. If there is a discrepancy, contact the Provider Participation Unit at 217-782-0538.
P04	Invoice Invalid For Provider Type	The charge was submitted on a claim form which is inappropriate for the provider type. The service(s) must be rebilled on the appropriate form. Check the Provider Information Sheet to verify the provider is correctly identified on Department records. If the sheet appears incorrect, contact the Provider Participation Unit at 217-782-0538.
P05	Provider Number Not On File	A claim was received with a provider number not listed in the Department files. Review claim records to ensure that the correct provider number was submitted. If an error was found, rebill with a new claim using the correct provider number. To enroll, the provider must contact the Provider Participation Unit at 217-782-0538.

Error Code	Message	Explanation
P06	Provider Name Does Not Match Provider Number	A claim was received with a provider name other than the name carried on Department files for the provider number entered on the billing form. Review the Provider Information Sheet for the correctness of both the provider name and number. If the Provider Information Sheet reflects information that is incorrect or out of date, make the correction on the Provider Information Sheet and submit it to the Provider Participation Unit at 217-782-0538. If the Provider Information Sheet is correct, submit a new claim, with the provider name entered exactly as it appears on the Provider Information Sheet.
P07	Service Not Allowed Per Department Review	A claim previously suspended due to an audit has been rejected. Do not rebill. The provider has been officially notified that their participation in the program has been terminated.
P09	Fee-For-Service Invalid For UB Bill	UB-04, 837I or Institutional DDE: A claim was received that contained the hospital's fee-for-service provider number. Resubmit the claim with the appropriate Provider Number. Paper claims submitted on or after May 01, 2008 must be billed on the UB-04 and in accordance with the UB-04 billing instructions.
P13	Tax Levy Exception	The Internal Revenue Service has notified the Department that a lien has been levied against payments made by the Department to the provider number on the claim. All monies payable have been re-directed until IRS lifts the levy.
P15	Reported Payee Not Found	The payee code received on the claim identifies a payee who was not authorized on the date(s) of service. Review the Provider Information Sheet to determine if the desired payee has been properly identified to the Department. The provider may request a change to the listed payee by contacting the Provider Participation Unit at 217-782-0538. Submit a new claim with a valid payee code.

Error Code	Message	Explanation
P18	Service Under Review By Exception Review	
P19	Services Not Allowed By Provider Services	NIPS: The Bureau of Comprehensive Health Services has caused the service to be suspended for special review. The service was then rejected as inappropriate for payment. Do not rebill. Institutional: The provider is delinquent in submitting their cost report to the Department. No payments will be issued until receipt of the aforementioned report. Please contact a UB-92 billing consultant at 1-877-782-5565.
P20	RX Practitioner Not Identified	A service was received with the Prescribing Practitioner field blank. A new claim with the missing data included should be submitted.
P24	No Delivery Privileges On File	A claim for a prenatal visit was received, but the Department files do not indicate that the physician rendering the service has either delivery privileges or an agreement with a physician who has delivery privileges. Contact the Provider Participation Unit at 217-782-0538 to obtain the necessary forms to identify the provider's delivery privileges or agreement with another physician who has delivery privileges.
P48	Non-Participating Provider/Returned Mail Contact Department	Contact the Provider Participation Unit at 217-782-0538 to verify enrollment information.
P49	Limited Enrolled Provider/Contact Department	NIPS: The provider has submitted a claim for services when he has been enrolled with the Department in a "limited" status. Contact the Provider Participation Unit at 217-782-0538.
P50	Review Of Provider Information	The claim has been temporarily suspended for Department review. The final status of the claim will be reported on a future Remittance Advice. Do not rebill.
P52	Monies Diverted To IRS For Tax Levy	The Department has been ordered to re-direct the provider's warrants to IRS because of an outstanding tax levy, wage garnishment, etc.

Error Code	Message	Explanation
P59	Care Not Appropriate For Children's Hospital	The claim was submitted for a children's hospital where: the participant was 18 years of age or older on the date of admission, or the participant was under age 18, but Taxonomy Code for Inpatient Psychiatric or Taxonomy Code for Inpatient Rehabilitation was used, or the principal diagnosis code was in the range 290 through 302 or 306 through 319, or the DRG code is in the range 370 through 384 or the DRG code is 391. Review the medical records and the coding on the rejected claim for correctness. If an error is found, submit a correct claim. If assistance is needed, contact a hospital billing consultant.
P60	Care Not Appropriate For Adult Hospital	The claim was submitted with an adult hospital number and the patient is under age 18 on the date of admission and either the a General Inpatient Taxonomy Code was submitted on the claim and the DRG code is not in the range 370 through 384 or is not DRG code 391, or the an Outpatient General Taxonomy Code was submitted on the claim and the Principal Diagnosis code is not in the range of 630-677, V22, V23, V26 or an Outpatient Renal Dialysis Taxonomy Code was submitted on the claim and the Principal Diagnosis code is not in the range of 630-677, V22, V23 or V28.
P66	Payee Not Certified Submit W9 Form To Correct	According to the Department's records, the requested payee has not been certified to the Office of the Comptroller. Payments can be made only to certified payees. Contact the Provider Participation Unit at 217-782-0538 to obtain the necessary form to certify the payee.
P67	DRG Reassignment Review Rejection	The claim has been reviewed by the Peer Review Organization. It has been determined that a different diagnosis code would more accurately reflect the services provided. Make the appropriate corrections and rebill a hard copy claim with the Advisory Notice attached.
P70	Prescribing Physician Is Terminated By HFS	A claim was received with the Prescribing Practitioner Number of a physician who has been terminated by the Department. Prescriptions from terminated physicians will not be honored by the Department.

Error Code	Message	Explanation
P74	Occurrence Code Required	Submit a correct claim indicating the proper Occurrence Code.
P81	Payee Valid For CBO Payment Only	A claim was received with an Early Intervention Payee designated.
P90	Invalid Reimbursement Rate Segment On PDB	
P93	Procedure Illogical For Provider	Contact your hospital's billing consultant at 1-877-782-5565.
P97	Prov Type/ Doc CD/COS Comb Not Allowed	A claim was received on a billing document which the provider is not eligible to use based on the provider type under which they are enrolled. Contact a NIP's billing consultant at 1-877-782-5565 for assistance.
P98	Default Payee Used	The payee code submitted on the claim was not valid for the Date of Service (NIPS) or the End Date of Service (Institutional) shown. A default payee, from the provider's information on file, was used to report the rejection of the claim. Review Provider Information Sheet to determine which payee was active on the Date of Service. Rebill the service on a new claim with the proper payee code.
P99	Provider Uncollected Debt/Contact Department	The provider has submitted a claim for services but has an uncollected debt with the Department. Contact a billing consultant at 1-877-782-5565.

Error Code	Message	Explanation
R01	No Record Of Recipient Number	A claim was submitted with a Recipient Identification Number that does not match the Department's eligibility files. Rebill on a new claim including the correct Recipient Identification Number.
R02	Recipient Name Does Not Match Recipient Number	The patient name does not match the Department's eligibility files for the Recipient Identification Number on the claim. Patient name and number must appear exactly as on Medical Programs Card. Submit a new claim with correct information.
R03	Recipient Not Eligible On Date Of Service	A claim was received for a date of service which does not fall within the range of the patient's medical eligibility period. Review patient's records to ensure that the correct Recipient Identification Number was used for the dates of service being billed. If an error occurred, rebill with the correct date of service. If no error occurred, no payment can be made.
R04	Recipient Is Enrolled In HMO	Department records reflect that the participant was enrolled in a Managed Care Organization (MCO) on the date of service. Contact the MCO for reimbursement.
R05	Service Restricted Group Care Recipient	A claim was received for a service which is the responsibility of the Long Term Care (LTC) facility to provide. The provider should contact the local Department of Human Services office to obtain the name of the LTC facility in which the patient resides. The provider has the responsibility to seek reimbursement from the facility. Neither the Department nor the resident (or the resident's family) has an obligation for payment.
R06	Recipient Not Eligible On Date Of Service/ Spenddown Not Met	A claim was received for a participant who was in Unmet Spenddown status on the date of service. The participant is not eligible until Spenddown is met. Refer to Chapter 100, Topic 113.
R08	Prior Approval Denied-Established Patient	A claim was submitted for a service or item which requires prior approval, but prior approval was denied. No payment can be made.

Error Code	Message	Explanation
R09	Prior Approval Required	NIPS: A claim was submitted for a service which requires prior approval but no prior approval is posted on the Department's files. A prior approval request should be submitted for this service. After receiving Prior Approval, rebill the service on a new claim. CMH Claims: A prior approval is required because the authorization limit has been exceeded. Contact VO. Institutional: Review Procedure Codes to ensure that the correct procedure was submitted. For assistance, contact a UB billing consultant.
R10	Service Not Covered For Recipient Category	A claim was received for a service to a participant in a limited coverage program administered by the department. The procedure is not a covered service for this participant.
R11	Hysterectomy Form Invalid Or Missing	A claim was submitted for a service which required attachment of Form HFS 1977, Acknowledgment of Receipt of Hysterectomy Information. Either the claim lacked the required form or the form was invalid. If the required form was not submitted with the original claim, submit a new claim with the form attached. Submit both in a Special Handling Envelope (HFS 2248). If the required form was invalid, it will be returned with a copy of the claim and a letter specifying the rejection reason. If the form can be corrected, a new claim must be submitted with the form attached. Submit both documents in a Special Handling Envelope (HFS 2248).
R14	Prior Approval Prov Number Does Not Match	The provider number submitted on the claim does not match the department's prior approval system. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.
R15	Patient Deceased	A claim was received for a recipient with a date of service after his death date.

Error Code	Message	Explanation
R16	Services Invalid For Recipient Sex	The Procedure Code/Diagnosis/Revenue Code received is not appropriate for the sex of the patient. Refer to provider records to determine if the claim showed the correct revenue code, diagnosis and/or procedure. In addition, check to see whether the correct Recipient Identification Number was sent on the original claim. If an error in the original submittal is found, submit a new claim which includes the correct information. For assistance, contact a billing consultant at 1-877-782-5565.
R17	Services Invalid For Recipient Age	The Procedure Code/Diagnosis/Revenue Code received is not appropriate for the age of the participant. Refer to medical records to determine if the claim showed the correct revenue code, diagnosis and/or procedure. In addition, check to see whether the correct Recipient Identification Number was sent on the original claim. If an error in the original submittal is found, submit a new claim which includes the correct information. For assistance, contact a billing consultant at 1-877-782-5565.
R18	Suspended For New Born Eligibility Review	The Department is investigating the eligibility of the infant patient reported on a particular claim. Do not rebill. The final status of the service will be reported on a future Remittance Advice.
R19	Recipient Has Medicare Coverage Part B	A claim was received for a service to a participant who had Part B Medicare Coverage on the date of service. Bill the service to Medicare.
R23	Correct Spenddown Credit Not Shown	The correct Spenddown credit was not shown on the claim. Review Form HFS 2432 Split-Billing Transmittal for MANG Spenddown Program. Determine if the information on the Form HFS 2432 and the amount of spenddown shown on the claim are the same. Rebill on a new claim form showing correct information.
R24	Newborn Not Eligible For Assistance	A claim was received for a newborn that has been determined not eligible for assistance. Do not rebill.

Error Code	Message	Explanation
R29	Care Not Authorized By Primary Pharmacy	A claim was received for a service not billed by the Primary Care Pharmacy named on the participant's Medical Programs Card. A completed Form HFS 1662 (Primary Care Authorization Form) from the Primary Care Pharmacy authorizing services was not attached to the claim. The service(s) may be rebilled by completing a new paper claim and submitting it in a Special Handling Envelope (Form HFS 2248). A completed Form HFS 1662 from the PCP must be attached to the claim. Refer to Topic 106 for further information.
R30	Care Not Authorized By Primary Physician	A claim was submitted for a service not authorized by the Primary Care Physician (PCP) named on the participant's Medical Programs Card. A completed Form HFS 1662 from the PCP authorizing services was not attached to the claim. The service(s) may be rebilled by completing a new claim. A completed Form HFS 1662 from the PCP must be attached to the claim. Refer to Topic 106 for further information.
R33	Recipient Category Changed Mid-Stay	Department records indicate the patient's category of assistance has changed from a state funded category to a federally funded category or vice versa. Effective with such change, the claim must be split and submitted as separate interim claims. Contact a UB billing consultant for assistance.
R34	Services To Mental Health Recipient Limited	A claim was received for services provided to a participant institutionalized in a Department of Human Services (DHS) inpatient facility. The provider should contact the DHS facility regarding payment.
R35	Part A Service-Bill Medicare	The Department’s records show that the participant was eligible for Part A Medicare coverage on the date of service. The service submitted did not indicate that it had been previously submitted to Medicare. The service should be submitted to the Medicare Part A Intermediary for processing. If the service was submitted to Medicare but no response was received, contact the Medicare Intermediary to determine the disposition of the claim.

Error Code	Message	Explanation
R36	Part B Service- Bill Medicare	The Department's records show that the participant was eligible for Part B Medicare coverage on the date of service. The claim submitted did not indicate that it had been previously submitted to Medicare. The claim should be submitted to the Medicare Part B Carrier for processing. If the claim was submitted to Medicare but no response was received, contact the Medicare Carrier to determine the disposition of the claim. Submit a corrected claim. NIPS Only: If the claim was previously submitted to Medicare and denied, attach a copy of the Explanation of Medicare Benefits (EOMB) to the claim when it is rebilled.
R39	Recipient Has Prepaid Full Service Plan	A claim was submitted for services rendered to a participant who is a member of a Managed Care Organization (MCO) with full service coverage. Do not rebill. Contact the MCO for payment.
R40	Group Care Item Only	The item or service which was billed is restricted for payment to residents of a Long Term Care (LTC) Facility. Department records indicate that the participant was not a resident of an LTC Facility on the date of service. Review the medical records and the rejected claim to insure that the item or service, the resident, and the date of service were correct. If an error was made the service may be rebilled on a new claim.

Error Code	Message	Explanation
R41	Prior Approval Not On File	A claim requiring a prior approval was received but no corresponding prior approval could be found in the Department's records. If the provider's records contain an approved prior approval request for the service, review the claim to ensure that it contains the correct item number, date of service and Recipient Identification Number. If not, submit a new claim form with corrected information. If the provider has not requested a prior approval, or if the prior approval contains incorrect information, contact the Prior Approval Unit for assistance.
R42	Prior Number Not On File For Date Of Service	A claim was received with a prior approval which does not cover the date of service. Review records to ensure that the date of service submitted is correct. If the date is incorrect, submit a correct claim to the Department. If the date of service is correct but does not match the date or date range covered in the existing prior approval, contact the Prior Approval Unit for assistance.
R43	HCPCS Procedure Code Required	The procedure code billed is not a valid HCPCS code according to Department files. The service may be rebilled on a new claim form by completing the entire service section using a valid HCPCS Level I (CPT IV) or Level II/III (alpha-numeric) procedure code.
R45	Obsolete Code - New HCPCS Code Required	A claim was received with a Level II/III alpha/numeric HCPCS code which is obsolete according to Department files. Refer to the coding source used in preparing bills to ensure that it is the most recent edition. If an incorrect code was used, rebill on a new claim form by completing the entire service section with the correct data. If no error is found, forward a new claim form and a letter documenting the source of the rejected code in a Special Handling Envelope (HFS 2248).
R46	Obsolete Code - See Current CPT IV	A claim was received with a procedure code that is obsolete. Verify that the most recent edition of CPT IV is being used. If an incorrect code was used, rebill the service on a new claim form by completing the entire service section with the correct data. If no error is found, forward a new claim form with the service section completed and a letter documenting the source of the rejected code in a Special Handling Envelope (HFS 2248).

Error Code	Message	Explanation
R48	Type Of Care Requires Authorization	Review Provider Taxonomy Code billed. When the service is Skilled Care (hospital residing), Exceptional Care (hospital residing) or DD/MI (hospital residing) an authorization form must be attached to the claim. For authorization, contact the Bureau of Long Term Care. For billing problems, contact a billing consultant at 1-877-782-5565.
R50	Review Of Recipient	The claim has been temporarily suspended for Department review. Do not rebill. The final status of the claim will be reported on a future Remittance Advice.
R51	Review Of Chronic Renal Dialysis Information	The claim has been temporarily suspended for Department review. Do not rebill. The final status of the claim will be reported on a future Remittance Advice.
R52	Spenddown Information Discrepancy	The participant had met their spenddown on the date of service and no HFS 2432 Split-Bill Transmittal for MANG Spenddown Program was attached, or the Recipient Liability Amount on the claim did not match the amount on the HFS 2432. Submit a correct claim with the HFS 2432 Split-Bill Transmittal for MANG Spenddown Program attached.
R53	Review Of Prior Approval	The claim has been temporarily suspended for Department review. Do not rebill. The final status of the claim will be reported on a future Remittance Advice.
R66	QMB Recipient Only Not Eligible For Medicaid	The patient was a Qualified Medicare Beneficiary (QMB) ONLY participant on the date of service and eligible for Department coverage of Medicare coinsurance and deductible only. Bill Medicare first.
R74	Services Not Covered For MPE	The Department's records indicate that the participant was covered on a Medicaid Presumptive Eligible (MPE) basis on the date of service. MPE provides coverage only for ambulatory pre-natal care such as physician and outpatient services. Other services are not payable. If the participant's status changes retroactively to full coverage under the Medical Assistance or KidCare Program, verify participant number and procedure codes and submit a new claim.

Error Code	Message	Explanation
R77	NDC Not Covered On Date Of Service	The NDC submitted is a valid code, but is not reimbursable by the Department for the date of service billed. Review claim data to verify both the NDC and date of service submitted. If an error was found, submit a new claim with correct data. If there are no errors, do not rebill as no reimbursement can be made. If you have any questions, please contact a Pharmacy billing consultant at 1-877-782-5565, option 7.
R78	DESI Drug Not Allowed For Payment	The Food and Drug Administration has determined this drug to be less than effective for all conditions of use prescribed, recommended or suggested in its labeling. No payment will be made for DESI drugs.
R79	Services Not Covered For GA-Adult Only- Case	A claim was submitted for an adult participant who has coverage under the State Transitional Assistance Program. Adult participants covered under this program are not eligible for hospital services.
R83	Recipient Enrolled In PHP Or County Care Health Plan	The Department's files indicate that the participant was enrolled in a County Care PHP on the date of service. The service provided was covered by the County Care PHP.
R84	Recipient Age Consistency	Review and verify recipient's date of birth and admit date that was submitted on the claim. Submit a corrected claim.
R86	NDC Is Terminated	The Date of Service on the submitted service is on or after the termination date for the NDC as shown on the National Drug Code database. Review the prescription to ensure that the correct NDC was billed. If questions arise, contact a pharmacy billing consultant at 1-877-782-5565.
R88	Participation Agreement Not On File	The provider billed the service in an electronic media without having a valid electronic enrollment on file. In order to bill electronically, the provider must submit a HFS Form 1413 Agreement for Participation to the Provider Participation Unit. Once the Provider database has been updated, a new Provider Information Sheet will be sent to the provider indicating that electronic submittal has been approved and claims may be submitted electronically. If the HFS 1413 is not on file, claims must be submitted on paper media.

Error Code	Message	Explanation
R89	Invoice Invalid For Hospice Patient	A claim was received with a service date that falls within a period when the patient was in a hospice program. Submit the claim to the responsible hospice. If the hospice denies the claim because the service was not related to the terminal illness, submit a new claim to the Department with the hospice denial notice attached.
R90	Diagnosis Inappropriate For Hysterectomy	NIPS: A claim was received with a hysterectomy procedure code and a diagnosis code which does not indicate the need for a hysterectomy. The medical records for the service should be reviewed to determine whether the use of a hysterectomy procedure code was appropriate. If the procedure code was correct, a new paper claim must be submitted with an appropriate diagnosis code. Each submittal of the hysterectomy procedure code must have a HFS Form 1977 Acknowledgment of Receipt of Hysterectomy Information attached. Institutional: If a hysterectomy procedure was performed there must be an accompanying hysterectomy diagnosis, other than the admitting diagnosis, on the claim.
R96	Recipient Not Enrolled For Hospice	A claim was received from a hospice for hospice services but the Department's records do not reflect that the participant was enrolled in a hospice during the service period being billed. Submit a Hospice Election Form to the Department if this has not already been done, and rebill the service. If a Hospice Election Form is already on file with the Department, review the dates on the claim to ensure they are within the date range on the Hospice Election Form. Changes or corrections to the dates on the Election Form must be submitted to the Department before the hospice services can be rebilled.
R97	Hospice Claim/ No LTC Revenue Code	A claim was received from a hospice for a resident residing in a Long Term Care facility on the date of service, but the Revenue Code of either 656 or 659 for dates of service less than 10/01/2003 or Revenue Code of either 656 or 658 for dates of service greater than 09/30/2003 was not coded on the claim. Submit a corrected claim.

Error Code	Message	Explanation
R98	Services Invalid For Interim Application	A claim was received with Recipient Identification Number 094334588. This Recipient Identification Number is used for medical transportation services only. Review the patient's record for the correct Recipient Identification Number. Submit a corrected claim.

Error Code	Message	Explanation
S01	Recipient In ILCares Rx Rebate Program	The participant has drug coverage through another insurer and has opted to receive a monthly rebate rather than drug coverage. This participant is not eligible for drug coverage.

Error Code	Message	Explanation
T03	TPL Amount Indicates Status Is Incorrect	Institutional: A TPL prior payment was listed on the claim with an incorrect TPL Status Code. Submit a corrected claim. NIPS: If a payment amount appears in the TPL Amount field then a value of 01 must be entered in the TPL Status field. Submit a correct claim.
T05	TPL Status Indicates TPL Amount Required	This service was received with a Third Party Liability Status of 01. This indicates a TPL amount greater than zero must be present in the TPL Amount field. Review the copy of the claim and patient records to determine the results of the TPL adjudication. Submit a new claim showing the correct TPL status or payment amount.
T07	Third Party Date Implies Illogical Status	A claim was received with a Third Party Liability Status of 07 (adjudication pending) but the TPL date is less than thirty days prior to the date the Department received the claim. In order for the Department to accept a claim with a TPL status of 07, 31 days must have elapsed between the ending date of service and the date of receipt of the claim. The provider should review patient records to determine if TPL adjudication has been completed. If not, then a new claim can be submitted after the 31 days have elapsed.
T09	Required TPL Code For Medicare Is Missing	The correct code for Part A Medicare is 909. The correct code for Part B Medicare is 910. Submit a corrected claim.
T10	TPL Adjudication Date Illogical	A service was received with a TPL Adjudication Date later than the date the claim was prepared. The provider should review the patient's record to verify whether the TPL Adjudication Date or the original claim preparation date was incorrect. Submit a new claim with corrected information.
T12	Insufficient TPL Data-Contact Department	A claim was received with insufficient Third Party Liability Data in the TPL sections of the claim to properly price the service. Contact a billing consultant at 1-877-782-5565.

Error Code	Message	Explanation
T21	Recipient Has Third Party Coverage	The Department's records indicate that the participant had third party coverage, but no TPL information was reported for this claim. Review patient's Medical Programs Card for TPL source information. The claim must be submitted to the third party payer before a new claim, with TPL information, can be submitted to the Department.
T32	Third Party Source Not Identified	This service was received with an unlisted TPL Code (999) and the name of the TPL payment source was not entered. The service should be rebilled with the appropriate TPL payment source reflected on the claim.
T35	TPL Status Invalid	An institutional claim was received with status code 10 and a Prior Payment amount greater that zero. Review copy of submitted claim to ensure correct status code is used or remove Medicare payment amount and insert the Medicare deductible. Submit a corrected claim.
T36	Submittal Time Limit/TPL Status 07 Not Met	A claim was received with a TPL status of 07, but the TPL date on the claim is less than 31 days prior to the date the Department received the claim. There must be 31 days from the end date of service and date of receipt by the Department. Submit new claim after 31 days have elapsed.
T37	TPL Edit Bypass Pregnancy Related	Payment is authorized for pregnancy related services to a patient with TPL coverage. Department will contact insurance carrier. No action required. Message for information only.
T38	TPL Edit Bypass Preventative Services	Payment is authorized for preventative services to a patient with TPL coverage. Department will contact insurance carrier. No action required. Message for information only.

Error Code	Message	Explanation
T40	Medicare Beneficiary Has Additional TPL	NIPS: A claim was received for a participant covered by third party insurance in addition to Medicare B, but no TPL information was submitted with the crossover claim. The third party should be billed as a secondary payer after Medicare B has approved the charges. If the third party makes payment and an unpaid amount remains, submit a claim form with the Medicare EOMB and a TPL EOB verifying TPL information. If the third party makes no payment or no liability is in force on the date of service, submit documentation of this fact and the Medicare EOMB with the claim. Institutional: A claim was received for a participant covered by third party insurance in addition to Medicare Part A and or Medicare Part B, but no additional TPL information was submitted on the claim. The third party should be billed and prior payment information is to be reported in addition to Medicare payment information. Submit a corrected claim.
T41	Missing Medicare Payer	If the claim is a Medicare crossover claim and TPL code 909 (inpatient) or 910 (outpatient) is present, then the first characters of the payer line must be either Medicare or code 98910.
T44	Additional 910 MB Invalid	A Medicare Crossover claim was received for a participant and there was TPL information (TPL Code 910) reported at the claim level only. If the TPL information is reported at the Claim Level and the Service Line Level, the Claim Level TPL must equal the total of the Service Line Level TPL.
T46	TPL Invalid On Illinois Medicaid Line	For institutional billing, review payer information. There should be no prior payment and/or TPL code across from the Illinois Medicaid line. Correct and submit a new claim.
T47	No Medicare Allowed Amount	A Medicare Crossover claim was received for a participant and the Provider Charge/Allowed Amount was zero or blank.

Error Code	Message	Explanation
T48	Missing Coinsurance And/Or Deductible Amts	A Medicare Crossover claim was received for a participant and there was a service section that was blank or zero for both the coinsurance and deductible fields.
T50	Review Of TPL Information	The claim has been suspended for Department review. The final status will be reported on a future remittance advice.
T87	Telehealth Originating/Distant Invalid	Two claims were received, both submitted by encounter clinics, for the same recipient and modifier GT was reported. If the Originating Site is an encounter clinic, the Distant Site provider or encounter clinic may not seek reimbursement from the department for their services. The Originating Site encounter clinic is responsible for reimbursing the Distant Site encounter clinic.
T89	Telehealth Distant Provider Invalid	A claim was received for a provider type that is not eligible to seek reimbursement as a telehealth distant site provider. Physicians, podiatrists, APNs, ERCs, FQHCs or RHCs are the only providers eligible to seek reimbursement as a distant site provider. If an error occurred, rebill with the correct information. If no error occurred, no payment can be made.
T96	Telehealth Originating Provider Invalid	A claim was received for a provider type that is not eligible to seek reimbursement as a telehealth originating site provider. Physicians, podiatrists, local health departments, community mental health centers, outpatient hospitals, ERCs, FQHCs and RHCs are the only providers eligible to seek reimbursement as an originating site provider. If an error occurred, rebill with the correct information. If no error occurred, no payment can be made.
T97	Telehealth Distant Place of Service Invalid	A claim was received for a telehealth service rendered by a distant site provider in an encounter clinic setting or a hospital with a place of service other than outpatient. Individual providers may not seek reimbursement for telehealth services rendered in an encounter clinic setting. The clinic is responsible for seeking reimbursement as appropriate. If an error occurred, rebill with the correct information. If no error occurred, no payment can be made.

Error Code	Message	Explanation
T98	Telepsychiatry Provider Invalid	A claim was received for a provider who does not have proof of completion of a psychiatric residency on file with the Department. If the provider of service is a psychiatrist who has completed a psychiatric residency, please contact the Provider Participation Unit at 217-782-0538 to obtain the necessary forms needed to update the provider file. If the provider does not hold the appropriate certification, they cannot bill for the services.
T99	Telehealth Originating Place of Service Invalid	A claim was received for a telehealth service rendered by an originating site provider in an encounter clinic setting or a hospital with a place of service other than outpatient. Individual providers may not seek reimbursement for telehealth services rendered in an encounter clinic setting. The clinic is responsible for seeking reimbursement as appropriate. If an error occurred, rebill with the correct information. If no error occurred, no payment can be made.

Error Code	Message	Explanation
U01	Duplicate Drug Therapy/Previously Disp	The drug being billed is a therapeutic duplicate of a drug previously paid for this participant. Please review data on claim for accuracy. If the data was submitted in error, correct the element(s) in error and resubmit. If no error was found, provider should request a Refill-Too-Soon (RTS) override if clinical justification exists. The claim can be resubmitted if the RTS is approved. Please contact a Pharmacy billing consultant at 1-877-782-5565, option 7, for assistance if needed.
U06	Approval Of Stay Not Entered	A hospital inpatient claim was received lacking a required entry in Condition Codes. Condition code C1 or C3 must be present. Submit a corrected claim.
U14	Interim Claim Must Be At Least 30 Days	A hospital or unit exempt from DRG payment methodology has submitted an interim claim for a period of less than 30 days. Rebill for 30 days of service or more. Note: Interim claims are not allowed for hospital stays subject to DRG payment methodology.
U16	Missing/Invalid New/Refill Indicator	A claim was received with a blank or with non-numeric values in the New/Refill field. Submit a new claim with the New/Refill field completed to reflect the correct dispensing of the prescription.
U17	Exceeds Authorized Refill Number	The numeric value in the New/Refill Number field is greater than the number of refills authorized. If additional refills are needed, a new prescription is required.
U18	Missing/Invalid Number Of Days Supply	A claim was received with a blank or with non-numeric values in the Days Supply field. Submit a new claim with the Days Supply field completed to reflect the correct dispensing of the prescription.
U19	Exceeds Maximum Days Supply	A claim was received with a value in the Days Supply field which exceeds the Department's maximum quantity allowed for the particular drug. Normally, a one month supply of the drug is to be dispensed at one time. Exceptions to this rule are granted to the following Specific Therapeutic Classes: oral contraceptives, inhalers or prenatal vitamins. For further assistance, contact a pharmacy consultant at 1-877-782-5565.

Error Code	Message	Explanation
U20	Missing/ Invalid DAW Code	A claim was received with a value in the Dispensed as Written field that was blank, contained non-numeric characters or contained a value other than 01 through 06 or 09. Resubmit the claim with the correct value.
U21	Missing/Invalid Date Rx Written	A claim was received with a value in the Date RX Written field that was blank or contained non-numeric characters or was not in the MMDDYY format. Resubmit the claim with the correct value.
U22	Date Rx Written After Date Of Service	A claim was received with a value in the Date of Service field that precedes the date in the Date RX Written field. Resubmit the claim with the correct values.
U23	Missing/Invalid Compound Code	A claim was received with a value in the Compound Code field that was blank or contained a numeric value that was not between 0 and 2. Resubmit the claim with the correct values.
U25	Refill-Too-Soon	A refill was requested prior to the use of a specific quantity of the drug. If a valid reason exists for an early refill contact a consulting pharmacist at 1-877-782-5565.
U26	Missing/Invalid Covered Days For Series Bill	A claim was submitted on which Covered Days contained either a blank or non-numeric characters. The number of series days for which outpatient services were provided must be reported in Covered Days. Resubmit the claim with valid values.
U27	Series Days Exceed Date Span	A claim was submitted on which Covered Days exceeded the number of days indicated in the Statement Covers Period. Submit a corrected claim.
U28	Series Units Less Than Days Billed	Covered Days contains a number that is greater than the calculated sum of "units" in Service Units for the series billable Revenue Code. Submit a corrected claim.
U29	Multiple HAR Groups Not Valid For Series Bill	Outpatient series bills cannot contain procedures from more than one APL group. Contact a hospital billing consultant for assistance.

Error Code	Message	Explanation
U30	Series Bill Exceeds Allowable Date Span	Statement Covers Period contains more days than allowed. A maximum of 31 days may be billed on one series outpatient claim. Submit a corrected claim. If necessary, submit more than one outpatient series claim, of no more than 31 days each.
U31	Series Bill Revenue Code Required	Series claims must contain at least one series billable Revenue Code. Review the medical record and submit a corrected claim.
U32	Procedure Not Valid For Series Bill	Series bills must contain at least one APL procedure which has been approved for series bills. Review the medical record and submit a corrected claim.
U33	Refill-Too-Soon-LTC	A pharmacy refill claim was received for a participant shown in the Department's records as residing in a Long Term Care facility on the Date of Service. A refill was requested prior to the use of: • a specific quantity of this drug or • a specific quantity of this drug plus the prescribed quantities of like drugs exceeds the Department's Monthly Maximum Quantity. If a valid reason exists for an early refill, contact a consulting pharmacist at 1-877-782-5565.
U34	Diagnosis Not Valid For Date	The Diagnosis Code was not valid for the date of service. Consult the medical record and the ICD-9-CM (or upon implementation, ICD-10) edition in effect on the date of service.
U35	Non-Covered Occurrence Span Dates Outside Statement Covers Period	Dates shown in Occurrence Span are not within Statement Covers Period. Review the medical record and submit a corrected claim.
U36	Non-Covered Occurrence Spans Overlap	Dates shown in Occurrence Code (Occurrence Span) overlap each other. Review the medical record and submit a corrected claim.
U37	Claim Type X Invalid For Hospice	Hospice services for recipient with Medicare Part A are not billable to the Department.
U38	Hospice/LTC REV Code Invalid For Recipient	A hospice claim was received where the number of days represented by the Total Number of Units of all 659 Revenue Codes for dates of service less than 10/01/2003 or 658 Revenue Codes for dates of service greater than 09/30/2003 is greater than the number of days that the patient resided in a Long Term Care facility. Review the medical record and submit a corrected claim.

Error Code	Message	Explanation
U43	Duplicate Rx Number For Different Recipient	A prescription was received with the same RX number and the same Date of Service as a previously paid prescription for a different patient. Review the patient's file to ensure that the correct information is being submitted. Submit a correct claim.
U44	Duplicate ECP Submission	The prescription received matches an electronically submitted prescription which is pending payment, but which has not yet appeared on a Remittance Advice. Payment for the first submittal will be reported on a future Remittance Advice. Do not rebill.
U45	Duplicate Rx Number For Different NDC	The prescription was received with the same RX number, same Recipient Identification Number and the same Date of Service as a previously paid service, but with a different National Drug Code. Review the patient's file to determine which NDC was dispensed. If the previously paid service was incorrect, submit an adjustment to void that claim and then submit a claim for the correct NDC.
U49	Missing Bed Reserve 41 For Hospice Claim	The Department's Long Term Care (LTC) records do not indicate a bed reserve type "41". This type of bed reserve permits the LTC room and board payments to be directed to the hospice. Contact a UB billing consultant for assistance.
U51	Renal Revenue Cd Combination Not Allowed	A claim was received which contains an unallowable combination of Revenue Codes. When billing outpatient ESRD, revenue codes 82X, 83X or, 88X may not be shown with revenue codes 841 or 851 on the same claim. Series claims for renal dialysis must be split if the patient received more than one type of dialysis during the treatment span.
U52	Service Allowed For FQHC/ERC Facility Only	A claim was received with a procedure code used only by Encounter Rate Clinics, but the provider is not enrolled as an Encounter Rate Clinic (Provider Types 40 and 43). If the provider is not an Encounter Rate Clinic, submit a new claim with the correct procedure code. If the provider is an Encounter Rate Clinic, contact the Provider Participation Unit at 217-782-0538 to correct the Department's files.

Error Code	Message	Explanation
U53	Procedure Code Not Allowed For Nurse Practitioner	A claim was received for a service that a Nurse Practitioner is not allowed to bill. Review the patient's record to determine whether the correct procedure code was submitted. If an incorrect procedure code was submitted, rebill on a new claim using the correct information.
U54	Service Only Allowed For Child	A claim was received for a service that is covered only for children, but the patient was over the age of 21 on the date of service. Refer to the records to ensure that the correct Recipient Identification Number was used. If an error is found, submit a new claim which includes the correct information.
U55	ASTC Crossover Cannot Be Billed On UB	A Medicare crossover claim was received from an ASTC (Ambulatory Surgical Treatment Center) on a UB/837I/Institutional DDE. Bill the service to Medicare on a HCFA 1500.
U56	ASTC Service Invalid For Document Type	An ASTC (Ambulatory Surgical Treatment Center) billed for a procedure on a Form HFS 2360 that should have been billed on a UB/837I/Institutional DDE. Resubmit the claim with the proper procedure code.
U58	Provider Not Allowed To Bill For Service	A claim was received for services that cannot be billed by this provider type. For further assistance, contact a billing consultant at 1-877-782-5565.
U59	Diagnosis Code Not Allowed For Service	A claim was received from an Optometrist for a service that is allowed but the primary diagnosis code is not logical for the procedure. Refer to the records to ensure that the correct diagnosis code was used. If an error is found, submit a new claim which includes the correct information.
U60	Service Units Greater That Covered Days	For hospice claims, the Service Units for Revenue Codes 0651, 0655, 0656, and 0657 cannot exceed the covered days. Each Revenue Code must be compared to the covered days.

Error Code	Message	Explanation
U61	Service Allowed For RHC Only	A claim was received with a procedure code used only by Rural Health Clinics, but the provider is not enrolled as a Rural Health Clinic (Provider Type 48). If the provider is not a Rural Health Clinic, submit a new claim with the correct procedure code. If the provider is a Rural Health Clinic, contact the Provider Participation Unit at 217-782-0538 to correct the Department's files.
U62	Anesthesia Modifier Required	A Medicare Crossover claim for anesthesia services was submitted with either a missing or an invalid modifier on the claim. Submit a new claim with correct information.
U64	Type Of Bill Invalid For Provider Type	The entry in Type of Bill is incorrect for an Ambulatory Surgical Treatment Center (ASTC) or the Type of Bill indicates ASTC but the billing provider is not an ASTC. Submit a corrected claim.
U65	NDC Not Valid For Date Of Service	A prescription was received for an NDC that is missing certain data on the Department's National Drug Code database. This data is required to determine the correct reimbursement for this item. Contact a pharmacy consultant at 1-877-782-5565.
U66	Missing HCPCS Code For Revenue Code	For Outpatient ESRD claims, Revenue Code 0636 requires a HCPCS code.
U67	Epogen Charge Required For Value Code 68	For ESRD, when a value code of 68 is present, there must be a charge for epogen (Revenue Code 634 or 635) on the claim. Review the medical record and submit a corrected claim.
U68	Incorrect Covered Days For Renal Services	When billing for home daily dialysis revenue codes 841 or 851, the sum of Covered Days plus Noncovered Days must equal the Statement Covers Period. Review the medical record and submit a corrected claim.
U70	Admitting Diagnosis Not From ICD-9-CM (or upon implementation, ICD-10)	A claim was received with an invalid Admitting Diagnosis Code. Review the patient's record and ICD-9-CM (or upon implementation, ICD-10) manual to determine correct diagnosis code.
U71	E-Code Not From ICD-9-CM (or upon implementation, ICD-10)	A claim was received with an invalid E-Code (diagnosis). Review patient's record and ICD-9- (or upon implementation, ICD-10) CM manual to determine the correct coding. Submit a corrected claim.

Error Code	Message	Explanation
U72	Invalid Admitting Diagnosis Code	A claim was received with an invalid Admitting Diagnosis Code. Review the patient's record and ICD-9-CM (or upon implementation, ICD-10) manual to determine the correct diagnosis code. Submit a corrected claim.
U73	E-Code Invalid As Principal Diagnosis	A claim was received with an E-Code as the Principal Diagnosis Code. E-codes are not acceptable as a principal diagnosis code. Review the medical record to determine the appropriate principal diagnosis. Submit a corrected claim.
U74	Invalid E-Code	A claim was received with an invalid E-code (diagnosis) in one of the External Cause of Injury Code (EIC) fields. Submit a corrected claim.
U75	Missing Admitting Diagnosis Code	The Admitting Diagnosis Code FL76 was missing on the submitted claim. This is a required field on an inpatient claim.
U76	General Care Not Approved For COS 21	When billing for inpatient psychiatric services (psychiatric taxonomy code), there must be a diagnosis code in the range of 290-302, 306-319, 648, and 995. Review the medical record to determine the correct diagnosis code and provider taxonomy code. Submit a corrected claim.
U80	Condition Code Required For Abortion	Review Condition Codes. A condition code of A7, A8 or 96 is required if an abortion procedure is listed. Review the medical record and submit a corrected claim.
U81	Procedure Invalid For Condition Code	A claim was received with an illogical combination of Condition Codes and Procedure Codes. If a Condition Code of A7, A8 or 96 is listed, an abortion procedure code is required. Review the medical record to determine which entry is in error and submit a corrected claim.
U82	Multiple Abortion Condition Codes Invalid	A claim was received which had more than one abortion Condition Code listed. Review the medical record and select the single most appropriate code. Submit a corrected claim.

Error Code	Message	Explanation
U83	Recip Not Enrolled By Prov On DOS	A claim was received for hospice services, but Department records do not indicate that the participant was enrolled by the billing hospice on the date(s) of service. If the claim is correct, submit a Notice of Hospice Election. Allow two weeks for Department processing before submitting a new hospice claim. If the original claim was incorrect, submit a correct claim.
U84	Outpatient Series Claim Crosses 07/01/04 Must Be Split	Outpatient series claims that cross July 01, 2004 must be split. Does not apply to outpatient ERSD claims.
U85	Non-Covered Occurrence Span Dates = Statement Dates	Occurrence Code 74 or 80 non-covered date span cannot be the same as the statement covers period.
U87	DPH Renal Claim Crosses Calendar Months	Outpatient ESRD claims for recipients on the State Chronic Renal Disease Program cannot cross calendar months.
U88	Missing / Invalid Value Code Info For Hospice	A claim was submitted with Revenue Codes 0651 and/or 0652, without Value Code 61 or the code was 61 with no valid CBSA code for where the service was provided. For claims with dates of service after 12/31/2007, Revenue Codes 0655 and 0656 require Value Code G8 with the CBSA code where the inpatient service was provided. Submit a corrected claim. If the original claim was correctly coded, contact a UB billing consultant at 1-877-782-5565.
U91	Recipient Is Not DCFS/Service Not Covered	A claim was received for a DCFS screening, but the patient Recipient Identification Number (RIN) did not belong to a DCFS ward. Review the patient's eligibility records. If the patient is a DCFS ward, submit a corrected claim with the correct RIN. .
U92	Provider Not Authorized For DCFS Screening	A claim was received for a DCFS screening, but the provider has not been authorized to provide these services. Contact a UB billing consultant at 1-877-782-5565 for assistance.
U94	Nurse Pract/Midwife Not Enrolled For COS	A claim was received for a category of service that was not billable by a Nurse Practitioner/Midwife.

Error Code	Message	Explanation
V21	Invalid Type Of Service/Role Code	A claim was received with a value in the Type of Service/Role Code field which is identified as illogical for the procedure code. Rebill with correct information. For assistance, contact a billing consultant at 1-877-782-5565.
V22	Invalid Sterilization/ Abortion Code	A claim was received with an invalid code in Field 23C (Sterilization/Abortion) on the HFS 2360. Refer to HFS 2360 billing instructions for the correct coding and rebill the service on a new claim.
V23	Missing/Invalid Place Of Service	A claim was received with either a blank or a code that is not a valid value for the place of service. Rebill on a new claim by completing the entire service section including the appropriate place of service code.
V24	Missing/Invalid Provider Charge	A claim was received with either a blank or non-numeric value in the service line Charges/Provider Charge field. Rebill on a new claim by completing the entire service section including the Charges/Provider Charge field.
V25	Missing/Invalid Balance Due/Net Charge	A claim was received with either a blank or non-numeric value in the Balance Due field. Rebill on a new claim by completing the entire service section including the Balance Due field.
V26	Missing/Invalid Number Of Services	A claim was received with either blanks or a non-numeric value in the "# Sects" field. Rebill on a new claim with the #Sects field completed. Count all non-deleted service lines.
V27	Anesthesia Requires Modifying Units	A claim was received with either a blank or an invalid entry in the Modifying Units field for an anesthesia service. Rebill on a new claim by completing the entire service section.
V41	Missing Referring Practitioner Number	A claim was received with a blank in the Referring/Ordering Practitioner Number field. Submit a new claim with the Referring/Ordering Practitioner Number field completed.
V60	Missing/Invalid Purchase/ Rental Code	A claim was received with either a blank or an invalid value in the Purchase/Rental Code field. Rebill on a new claim with a valid value in this field.
V61	Missing/Invalid Orig Or Dest Place Code	A claim was received with an invalid origin or destination modifier. If an error occurred, rebill with the correct origin or destination modifier. If no error occurred, no payment can be made.

Error Code	Message	Explanation
V97	Restricted Services Condition Code Required	An outpatient claim was received for a participant who has coverage under the State Family & Children Assistance Program. To be eligible for payment, one of the following special conditions code must be indicated. True emergency room service which has been certified by E/R physician (Code 95). Surgery and related ancillary services which are contained in the Ambulatory Procedures List (Code 95). Cancer treatment procedures which are contained in the Ambulatory Procedures List (Code 95). Burn treatment including follow-up treatments of 2nd or 3rd degree burns if the procedures are contained in the Ambulatory Procedures List (Code 95). Renal Dialysis (Code 71-76). Review the medical record and submit a corrected claim if one of the above conditions applies.

Error Code	Message	Explanation
W37	Invalid Medicare Payment	The Medicare payment amount (Total Deductions field) is not numeric. This error is only created as a result of an error in the data entry of Department generated data. Resubmit the original crossover documentation for reprocessing.
W39	Invalid Medicare Cash Deductible	NIPS Billing: The cash deductible amount is not numeric. This error is only created as a result of an error in the data entry of Department generated data. Resubmit the original crossover documentation for reprocessing. Institutional Billing: Review Medicare Deductible amount. This field must be numeric. Submit a corrected claim.
W41	Invalid Medicare Coinsurance	NIPS Billing: The coinsurance amount, as entered, was not numeric. This error is only created as a result of an error in the data entry of Department generated data. Resubmit the original crossover documentation for reprocessing. Institutional: Review Medicare Co-insurance amount. This field must be numeric. Submit a corrected claim.
W42	Invalid Medicare Payment Date	NIPS Billing: The Medicare Adjudication date was not completed in the MMDDYY format. This error is only created as a result of an error in the data entry of Department generated data. Resubmit the original crossover documentation for reprocessing.
W44	Medicare Assignment Code Not Yes	The Assignment field on the Medicare crossover claim was not completed as “Yes”. The provider is required to accept assignment on claims billed to Medicare. Otherwise the Department cannot assume any patient liability for coinsurance and/or deductible. The original claim submitted to the Department should be reviewed. If a processing error occurred or there were extenuating circumstances as to why the provider failed to accept assignment with Medicare, resubmit the crossover claim with a letter of explanation in a Special Handling Envelope (HFS 2248).
W61	Recipient Not Enrolled In Designated Plan	Department records reflect that the participant was not enrolled in the managed care plan listed on the claim. Review patient's records to ensure that the correct Recipient Identification Number was used for the dates of service being billed. If an error occurred, rebill with the correct information. If no error occurred, no payment can be made.

Error Code	Message	Explanation
W71	Missing Origin Facility Name	A claim was received with blanks in the field used to identify the origin of the trip. Rebill the service section on a new claim.
W72	Missing Destination Facility Name	A claim was received with blanks in the field used to identify the destination of the trip. Rebill the service section on a new claim.
W73	Invalid Unit/Miles	A claim was received with a non-numeric entry in the Unit/Miles field. Rebill the service section on a new claim.
W74	Missing/Invalid Origin Or Destination Time	A claim was received with the Destination Time field either blank or containing a non-numeric value or a value which was not in the HHMM format. Rebill the service section on a new claim with the Destination Time field correctly filled in.
W77	Cash Deductible Exceeds Maximum	The Medicare deductible submitted on the claim exceeds the maximum amount for the year which is being billed. Submit a corrected claim.
W78	Coinsurance Exceeds Maximum	The Medicare co-insurance amount submitted on the claim exceeds the maximum amount for the year which is being billed. Submit a corrected claim.
W79	Missing Deductible/ Coinsurance	A claim was received which contained blank values in either in the Medicare Deductible or Medicare Co-insurance amounts for this Medicare/Medicaid crossover claim. Submit a corrected claim.
W82	Days Billed Exceed Days In Service Range	This outpatient Medicare/Medicaid crossover claim with a Taxonomy code for Outpatient Psychiatric Clinic Services Type ‘A’, Outpatient Psychiatric Clinic Services Type ‘B’ or Outpatient Physical Rehabilitation Clinic Services has a number of units in revenue code 0001 that is greater than the difference between the begin and end service dates. Submit a corrected claim.
W83	Invalid Number Of Total Units	Non-numerical characters were contained in Service Units for the number of departments visited for a Medicare/Medicaid crossover claim. Submit a corrected claim.
W84	Suspended For Information Update	The claim has been temporarily suspended for Department review. Do not rebill. The final status of the claim will be reported on a future Remittance Advice.

Error Code	Message	Explanation
W87	Number Of Renal Dialysis Services Exceed Maximum	The number of renal dialysis services billed exceeds the number of treatments allowed for the service period. Review the medical record and submit a corrected claim. If the number of renal dialysis services and the service period on the original claim are correct, contact a billing consultant for assistance.
W91	Coinsurance Exceeds Medicare Payment	A claim was received on which the Medicare Co-insurance amount billed is greater than the Medicare Payment amount. Submit a corrected claim.
W92	Medicare Part B Deductible Exceeds Maximum	A claim was received on which the Medicare Deductible amount billed exceeds the Medicare deductible for that year. Submit a corrected claim.
W93	Medicare Allowable Exceeds Total Charges	Review Total Charge; Medicare Deductible/Co-insurance and Medicare Payment. The amount Medicare allowed for the claim exceeds the total charges for the services. If amounts shown were in error, submit a correct claim.

Error Code	Message	Explanation
X01	Service Under Review By Medical Quality Assurance	Service has been rejected for review by the Bureau of Medicaid Integrity.
X03	One Initial Office Visit/ Exam Allowed	The Department will only allow one initial office visit per patient per physician. Review the original billing and patient files to ensure that the correct provider and participant numbers were entered. If an error was made rebill with the correct data. If no error was made, rebill the service using a procedure code for a visit for an established patient.
X04	Consultation Disallowed	A claim was submitted for an initial or confirmatory consultation after payment had previously been made to the same physician for an initial or confirmatory consultation, or a claim was submitted for a follow-up consultation without documentation. Refer to Chapter 200 policy on consultation services. If the repeat initial or confirmatory consultation was done at the request of the attending physician, rebill on a new claim attaching a copy of the consultation report. When the patient's condition requires more than one follow-up consultation, service(s) may be rebilled with a copy of the Hospital Discharge Summary. Submit the documents in a Special Handling Envelope (HFS 2248).
X05	Hospital Visit Disallowed	A claim was submitted for a hospital visit already paid to another physician for the same patient on the same date of service. Payment is not routinely allowed for daily hospital visits by more than one physician. Refer to Chapter 200 policy regarding concurrent care. If the patient's condition necessitates concurrent care, the physician may seek payment consideration by rebilling the service on a new claim and attaching a copy of the Hospital Discharge Summary. Submit the documents in a Special Handling Envelope (HFS 2248).

Error Code	Message	Explanation
X06	Surgical Package Previously Paid	A charge was submitted for a procedure/visit considered a part of the surgical service package, for example: hospital or office visits following major surgery during the thirty (30) day post-operative period, or a follow-up hospital or office visit on the day of a minor diagnostic or therapeutic procedure, or a surgical procedure considered an inherent part of another procedure and/or an "incidental" procedure. Refer to Chapter 200 policy relative to surgery. If the provider believes that the patient's condition required the additional service, he may seek payment by rebilling the service on a new claim with supporting medical documentation. If the visit was a consultation, the provider may rebill on a new claim with a copy of the consultation report attached. If the attending physician is submitting post-operative visit charges for an unrelated illness or service, attach a statement on the physician's letterhead explaining the nature of the injury or illness and a copy of the Admission History and Physical and the Hospital Discharge Summary. Submit the documents in a Special Handling Envelope (HFS 2248).

Error Code	Message	Explanation
X07	Maternity Care Previously Paid	A claim was submitted for a procedure/visit/consultation which is not allowed in combination with other billed/paid obstetrical services, or a claim was submitted for a delivery or Caesarean section which was previously paid to the same or a different physician. Refer to Chapter 200 for policy relative to maternity care. Review a copy of the rejected claim and medical records to determine if the correct information was shown (procedure code, date of service, participant name and number, delivering doctor/surgeon's name and Type of Service code). If an error is found, rebill on a new claim with the correct data. In some cases, payment records must be reviewed to determine if the claim is being rejected because it was previously paid under another service date or procedure code, for example, a Caesarean section was performed but a vaginal delivery was billed in error and paid. If payment has been received for an incorrect procedure code or service date, submit an adjustment. Refer to General Appendix 6 for instructions on adjustments. If payment was denied because another provider has already been paid for the delivery or Caesarean section, but the medical records verify that the delivery/c-section was actually done by the provider shown on the rejected claim, rebill on a new claim and attach a copy of the Delivery Room Record or Operative Report and a brief narrative explanation for the resubmittal. Submit the documents in a Special Handling Envelope (HFS 2248). If the original claim contained correct information and the provider believes the service should be allowed as a separate charge, submit a request for reconsideration by rebilling the service on a new claim with a statement on the provider's letterhead documenting the need for the service and with copies of any pertinent medical reports. Submit the documents in a Special Handling Envelope (HFS 2248).

Error Code	Message	Explanation
X08	Surgical Procedure Conflicts With Previously Paid Surgery	A claim was submitted which contains illogical information, when compared with another procedure which was already paid. For example: A claim was submitted for a previously paid surgical procedure which can only be performed once, e.g., appendectomy, cholecystectomy or circumcision. A claim was submitted for a "partial" procedure for a service date that is the same or later than the service date for a paid "complete" procedure, such as a salpingectomy or oophorectomy with or after a complete hysterectomy. A claim was submitted for a delivery after a hysterectomy. A claim was submitted for a "complete" procedure for a service date that is the same or before the service date for a billed/paid "partial" procedure, e.g., a total thyroidectomy before a subtotal thyroidectomy. Review the patient's medical records and a copy of the rejected claim to determine if the correct procedure code, service date, participant name and number were shown. If incorrect information was shown on the original claim, rebill on a new claim with the correct data. If correct information was shown on the original claim, the service should be rebilled on a new claim with a copy of the Operative Report or Delivery Room Record or other appropriate medical records to document the service. The Department will determine if the previously paid service was paid in error. Submit the documents in a Special Handling Envelope (HFS 2248).

Error Code	Message	Explanation
X09	Lab Procedure Previously Paid	A claim was submitted for a constituent part of another laboratory panel/test paid for the same service date. Review the claim information and the patient's medical records to determine if the correct procedure code and date of service were shown. If either was incorrect, rebill on a new claim with the correct data. If the information on the original claim was correct and all tests were done at the same time of the day, do not rebill as no payment can be made. If the laboratory procedure was done at a separate time of the same day, the provider may seek payment reconsideration by rebilling on a new claim. Copies of Lab Test Reports for all services billed for the date of service in question must be attached. Submit the documents in a Special Handling Envelope (HFS 2248).
X10	X-Ray Procedure Previously Paid	A claim was submitted for a constituent part of another x-ray procedure paid for the same service date. Review a copy of the claim and the patient's medical record to determine whether the correct procedure code and date of service were shown. If either was incorrect, rebill on a new claim with the correct data. If all the information on the original claim was correct and the x-rays were done at the same time of the day, do not rebill as no payment can be made. If the x-ray procedure was done at a separate time of the same day due to the nature of the patient's injury/illness, the provider may seek payment reconsideration by rebilling the service on a new claim. Copies of Radiology Reports for all x-ray services billed for the date of service in question must be attached. Submit the documents in a Special Handling Envelope (HFS 2248).
X11	Procedure Conflicts With Program Limits	A claim was submitted for an item that was previously paid and which is restricted for quantity or frequency or total quantity allowed within a given period. Refer to Chapter 200 for policy limitations on the type of item being billed. If further assistance is needed, contact a billing consultant.

Error Code	Message	Explanation
X12	One Psychiatric Visit Per Day Allowed	Payment has been made to the same or to a different provider for a psychiatric service on this service date. HFS allows one psychiatric service per patient per day. Exception: Electroconvulsive Therapy (ECT) is allowed in addition to any other psychiatric service.
X13	Oxygen Charge Previously Paid	A claim for oxygen was made within less than a month from the most recent paid oxygen claim. If the reason the claim is being submitted so soon is that the patient died or was discharged from a Long Term Care facility prior to the end of the month, a written explanation of the reason for the billing must accompany the claim. Submit the documents in a Special Handling Envelope (HFS 2248).

Error Code	Message	Explanation
X14	Anesthesia Service Conflicts With Previously Paid Anesthesia	Multiple claims were submitted by the same or different providers for anesthesia services for the same date of service. Payment is allowed for only one anesthesia service per operative session. The code for the major surgical procedure is to be billed and the total anesthesia time shown in Field 24F (Days or Units). Review a copy of the claim and the Anesthesia Record to determine if the date of service shown on the rejected claim was correct or if multiple surgery codes were billed for the same date of service. If the surgery date or any other information on the rejected claim was incorrect, the service should be rebilled on a new claim with the correct data. If multiple surgery codes were billed for the same operative session and payment was made for one, but the total anesthesia administration time exceeded the time shown on the claim for the paid service, an Adjustment Form HFS 2292 should be submitted. Refer to General Appendix 6 for instructions on preparing adjustments. If surgeries were done at separate times on the same day, the rejected service should be rebilled on a new claim with copies of both Anesthesia Records and a brief narrative explanation. Submit the documents in a Special Handling Envelope (HFS 2248). If payment was denied because another provider has already been paid for the anesthesia administration, but the medical records verify that the service was actually delivered by the provider shown on the rejected claim, the service should be rebilled and a copy of the Anesthesia Record attached. Submit the documents in a Special Handling Envelope (HFS 2248).

Error Code	Message	Explanation
X15	Visit Previously Paid	Payment has been made to this provider for a visit or consultation on this service date under a different procedure code. Payment is not routinely allowed for multiple visits on the same service date. Review the patient's medical record to determine whether the correct information (procedure code, date of service, etc.) was submitted on the original claim. If any information was incorrect, rebill on a new claim. If the rejected visit was for a different time of day than the previously paid visit, the provider may seek payment reconsideration by rebilling on a new claim. A narrative explanation of the medical necessity for the service must be attached. Submit the documents in a Special Handling Envelope (HFS 2248).
X16	Podiatry Procedure Conflicts W/Program Limits	A claim was submitted for a procedure/visit that was considered part of multiple other procedures.
X17	Healthy Kids Visit Previously Paid	A Healthy Kids screening visit or additional health exam was previously paid for the date of service shown. Review a copy of the rejected claim and medical records to determine if the correct information was shown on the claim (procedure code, service date, patient name, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Refer to payment records to determine which previously paid service caused the rejection.
X18	Healthy Kids/CPT IV Visits Conflict	Payment was previously made for a Healthy Kids service (screening visit, follow-up visit, make-up visit) or for a CPT IV office visit code for the same date of service. Payment is allowed for only one visit, screening or exam for a participant on a single service date. The provider should review a copy of the rejected claim and medical records to determine if the correct information was shown on the claim (procedure code, service date, patient name, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Refer to payment records to determine which previously paid service caused the rejection.

Error Code	Message	Explanation
X19	Immunization Previously Paid	A claim was received for an immunization code of a previously paid claim. Review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, participant, name, etc.). If the information was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Refer to payment records to determine which previously paid service caused the rejection.
X21	Healthy Kids Immunization One Time Only	Certain Healthy Kids immunizations are limited to one occurrence each in a participant's lifetime. Payment has previously been made for this immunization. Review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, patient name, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill.
X22	Measles/ Mumps/ Rubella Immunization Previously	A claim was received for an immunization code which includes one or more components of a previously paid claim for a Measles/Mumps/Rubella immunization. Review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, participant, name, etc.). If the information was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Refer to payment records to determine which previously paid service caused the rejection.
X23	Sickle Cell Test One Time Only	Payment for the Sickle Cell Test is limited to one occurrence in a participant's lifetime for the same physician. Review the rejected claim to determine whether all the information was correct. If an error is found, rebill with a new claim. If no error is found, do not rebill.

Error Code	Message	Explanation
X24	Renal Charge Daily/Full Month Previously	A claim was received for one or more days of renal dialysis that had previously been paid: The Department has previously paid the same or a different provider for a Dialysis code on the same date of service, or The claim was for monthly services during a period for which one or more daily services had previously been paid to the same or a different provider, or The claim was for daily services during a period for which a monthly service had previously been paid to the same or a different provider. The provider should review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, Recipient Identification Number, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Refer to payment records to determine which previously paid service caused the rejection.
X25	Complete Procedure Previously Paid	The provider billed for a component procedure code when a complete procedure code had been paid previously. The provider should review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, Recipient Identification Number, etc.). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Refer to payment records to determine which previously paid service caused the rejection.
X26	Equivalent Service Previously Paid	A claim was received for a procedure that had previously been paid for the same date of service.
X27	Component Services Previously Paid	The provider was previously paid for a component of the all-inclusive procedure code billed. Review a copy of the rejected claim and medical records to determine whether the correct information was shown on the claim (procedure code, service date, Recipient Identification Number). If any of the data was incorrect, rebill on a new claim. If all information was correct on the original claim, do not rebill. Refer to payment records to determine which previously paid service caused the rejection.

Error Code	Message	Explanation
X30	Procedure Conflicts With Program Limits	Charges were submitted for both a dispensing fee and a service fee for the same date of service. Do not rebill. The Department does not allow payment for both a dispensing fee and a service fee for the same date of service.
X32	Anesthesia Units Exceeds Department Maximum	The value submitted in field 24F (Days or Units) for the Anesthesia service exceeds the Department's maximum allowable quantity of 480 minutes (8 hours). If the Anesthesia time for the procedure exceeded the Department's maximum allowable, the service may be rebilled with a copy of the Anesthesia Record attached. Submit the documents in a Special Handling Envelope (HFS 2248).
X33	Illogical Quantity For Tests-Rebill With Lab/X-Ray Report	The value submitted in field 24F (Days or Units) for the number of tests performed for the Procedure Code identified exceeds the Department's standard. The physician should resubmit the service with medical documentation to support number of tests billed. Submit the documents in a Special Handling Envelope (HFS 2248).
X35	Surgical Assist Time Exceeds Department Maximum	The value submitted in field 24F (Days or Units) for the surgical procedure exceeds the Department's maximum allowable quantity of 480 minutes (8 hours) for an Assistant Surgeon. The service may be rebilled with a copy of the Anesthesia Record and Operative report attached. Submit the documents in a Special Handling Envelope (HFS 2248).
X37	Encntr/Visit Prev Paid Same Recip/DOS	A claim was received for an encounter visit that has been paid for this date of service and participant. Review the claim and if an error was made, rebill. If no error was made on the original claim, do not rebill. No payment can be made.

Error Code	Message	Explanation
X41	Prepay Review/DRG Code	The claim has been reviewed by the Peer Review Organization with one of the following results: • Chart was not available or case cancelled for review. Resubmit claim. • Partial denial of days.- submit a paper claim form to your medical consultant with a copy of the Advisory Notice from HSI. • DRG changes. Submit a paper claim form to your medical consultant with a copy of the Advisory Notice from HSI. Full denial - Do not rebill.
X42	KCAA Contact Completed Their Own Application	An application was filed by a KCAA, which they are not eligible for the TAP payments.
X44	Medical Only Requested Using 2378B	
X45	Missing/Invalid Date Of Birth	
X46	Date Of Birth Not Equal To Dept Files	
X48	Obsolete Third Diagnosis	A claim was submitted with an obsolete third diagnosis code(s). Review and resubmit claim with the appropriate code(s) that are in effect for the date of service being billed.
X49	Obsolete Fourth Diagnosis	A claim was submitted with an obsolete fourth diagnosis code(s). Review and resubmit claim with the appropriate code(s) that are in effect for the date of service being billed.
X50	Review Of Pricing	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.
X51	Review Of Initial Office Visit	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.
X52	Review Of Consultation	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.
X53	Review Of Hospital Visit	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.
X54	Review Of Visit/Surg/ Procedure	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.

Error Code	Message	Explanation
X55	Review Of Maternity Care	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.
X56	Review Of Surgical Procedure	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.
X57	Review Of Lab Procedure	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.
X58	Review Of X-Ray Procedure	The service has been temporarily suspended for Department review. Do not rebill. The final status will be reported on a future Remittance Advice.
X59	Obsolete Secondary Diagnosis	A claim was submitted with an obsolete secondary diagnosis code(s). Review and resubmit claim with the appropriate code(s) that are in effect for the date of service being billed.
X60	Obsolete Primary Diagnosis	A claim was submitted with an obsolete primary diagnosis code(s). Review and resubmit claim with the appropriate code(s) that are in effect for the date of service being billed.
X62	Duplicate Service In Process	A claim was received which is a duplicate of one currently being processed by the department. The final status of the claim being processed will be reported on a future Remittance Advice. The X62 supercedes any other error messages that may be received for the service line.
X64	Web App Proofs/Sign Sent After Submit Day	
X68	Match Claim Hold	Services billed by Provider Type 036, Community Mental Health Providers, Other Governmental Payers.
X73	Missing/Invalid Prior Approval Number	A claim was received with no prior approval number reported or the prior approval number that was reported did not match the prior approval number on the recipient's prior approval segment for the date of service billed.
X75	Missing/Invalid HCPCS For Obs Rev Code	Applies to outpatient claims with dates of service on and after 07/01/04. Revenue code 762 must have a corresponding HCPCS code as identified in the Ambulatory Procedures Listing on the department's Web site.
X78	Bilateral Procedure	A claim was received for a procedure billed with Modifier 50 and the procedure code billed is not appropriate with Modifier 50.

Error Code	Message	Explanation
X80	Checklist Not Attached Or Not Completed	
X81	Application Was Not Signed And Dated	
X82	All Relevant Questions Were Not Answered	
X83	Pages 1, 2, Or 3 Were Not Included	
X84	SSN Or Proof Of Appl For SSN Not Attached	
X86	Alien Reg No And Immigration Docs Not Prov	
X87	Preg Woman Applied/Pregnacy Not Verified	
X88	Sufficient Proof Of Income Was Not Attached	
X90	More Than Three Reasons	
X91	Application Previously Paid	
X92	Application Denied	
X93	Signed App Dt > 30 days	
X94	Applicants Signature Date Altered	
X95	Sufficient Proof Of Deductions Not Included	