Alliance Health

CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
1	45	Adjusted - Above contract rate	Post payment and any adjustment to charges. Do not refile.
2	92	Approved	Post payment and any adjustment to charges. Do not refile.
3	198	Authed units exceeded	Verify units authorized and provided. Contact Alliance Utilization Management for Authorization if applicable. Do not refile if authorized units are exceeded.
4	96	Basic units	No action needed. Package exceeded unit limit. Requires a new authorization.
5	29	Claim received after billable period	Write off charges as non billable. Do not refile.
6	110	Claim submitted before service date	Check DOS for accuracy. Refile only if incorrect. Do not bill service prior to service date.
7	22	Patient has other insurance which covers the service	Submit claim to primary insurance before submitting remainder due in ACS.
8	181	Patient not covered by contract	Check criteria listed in provider contract for patient eligibility. Confirm patient eligibility through Enrollment and Eligibility.
9	52	Clinician not licensed to provide the service	Review license detail for clinician listed on claim. If license is active and appropriate for service rendered, contact Provider Network to update clinician detail in ACS. Contact Claims Research Analyst to reprocess claim when updated.
10	2	Coinsurance Amount	Amount due from patient or responsible party. Do not refile claim.
11	59	Concurrent service has already been approved Cannot bill another one.	Review all services provided to member on that date. Adjust off as non-billable. Refile only if incorrect.
12	63	Correction to prior claim	Post payment and any adjustment. Do not refile.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
13	198	Daily limit exceeded	Units billed exceed units allowable per day for service on claim. Adjust off charges and do not refile. Contact Alliance Health Claims Research Analyst with questions.
14	204	Discontinued Service	Service has been lapsed/removed from benefit plan and is no longer billable. Contact Alliance Health Claims Research Analyst with questions.
15	18	Duplicate Claim	Claim has previously been submitted and adjudicated. Do not refile.
16	11	DX code is invalid for service/insurance combo	Verify that all diagnosis information is correct on claim and that primary diagnosis is in the correct position on the claim.
17	96	FFS claim pended for 14 days wait	No action needed. Await adjudication of claim. Do not refile.
18	31	Incorrect Member -- Patient not enrolled on DOS	Verify that all patient information is correct on claim. If no errors exist, contact Alliance Enrollment and Eligibility.
19	140	Incorrect Member -- Patient not enrolled on DOS	Verify that all patient information is correct on claim. If no errors exist, contact Alliance Enrollment and Eligibility.
20	181	Incorrect Service -- Service not in database	Verify that all service information is correct on claim. If no errors exist, contact Alliance Claims Research Analyst.
21	6	Invalid Age Group & PC combo	Verify that member age corresponds with procedure code billed and that all information is submitted correctly. Refile only if incorrect.
22	96	Invalid Amount	Enter charge information for service. Refile Claim.
23	9	Invalid diagnosis/Age combo	Verify that member Dx corresponds with member age and that all information is submitted correctly. Refile only if incorrect.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
24	11	Invalid PC / DX Combo	Verify that Procedure code corresponds with Dx and that all information is submittted correctly. Refile only if incorrect.
25	5	Invalid POS & Service combo	Verify place of service used for billing and that it is appropriate for the service billed. If incorrect, refile under a valid place of service.
26	208	Invalid Provider	Verify that provider information is correct on claim and is valid for the service billed. Contact Alliance Claims Research Analyst to update, then refile.
27	206	Invalid provider NPI #	Verify that provider NPI is correct on claim and is valid NPI for the service billed. Contact Alliance Claims Research Analyst to update, then refile.
28	206	Invalid Rendering NPI	Verify that rendering NPI is correct on claim and is valid NPI for the service billed. Contact Alliance Claims Research Analyst to update, then refile.
29	96	Invalid Units	Verify that the units are correct for service billed, and refile claim.
30	96	Monthly case rate already paid (TCM)	Service is generally no longer billable after 12/31/2012, but may be for EPSDT members. Contact Alliance Provider Network if disputing denial.
31	198	Monthly limit exceeded	Units for monthly service were exceeded. Do not refile claim.
32	147	No rates available	Rate not established in rate schedule. Contact Alliance Contract Manager.
33	46	Non billable Service	Service is not covered under Alliance Benefit Plan. Confirm correct service billed, and contact Alliance Claims Research Analyst if disputing denial.
34	96	Re-submission already processed	Duplicate claim. Do not refile claim. Contact Alliance Claims Specialist.
35	62	Service is not authorized	Verify Service Authorization for member. Contact Alliance Utilization Management for prior approval is no authorization is on file.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
36	181	Service not in contract	Review contract. Contact Alliance Health Contracts unit to resolve if appropriate. Contact Claims Research Analyst if service is added to contract and claim can be reprocessed.
37	181	Service not in provider profile	Service is not set up for provider. Contact Alliance Health Provider Network to resolve. Contact Claims Research Analyst if service added so claim can be reprocessed.
38	24	Subcapitated Provider/Service	Claim is reimbursed through monthly payment and not fee for service. Do not refile.
39	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	Verify the Taxonomy code filed for the claim. If incorrectly submitted, correct and refile. Contact Alliance Claims Research Analyst to add taxonomy code.
40	198	Weekly limit exceeded	Limit to occurrence of service billable per week. Adjust off charges and do not refile. Only if service is billed in error, file adjusted claim.
41	A1	Readju - Audit Payback	Claim read judicated by Alliance to effect payback due to audit of services. No action needed.
42	123	Readju - Audit Payback	Claim read judicated by Alliance to effect payback due to audit of services. No action needed.
43	125	Readju - Audit Recoup	Claim readjudicated by Alliance to effect recoupment of funds due to audit of services. No action needed. Bill any corrected service, if applicable.
44	62	Readju - Authorization/Treatment Revisions	Claim readjudicated by Alliance due to changes in authorization or treatment plan. No action needed.
45	125	Readju - Billing Days Extended	Claim readjudicated by Alliance due to extension of claims filing period.
46	125	Readju - Billing Terms Revised	Claim readjudicated by Alliance due to change in billing terms. Consult Contract documents or Alliance website.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
47	125	Readju - Client Manually Matched	Claim submitted without complete member information. Manually matched and readjudicated by Alliance. No action needed.
48	125	Readju - Contract Terminated	Claim readjudicated by Alliance to reflect end of contract ed provider status.
49	63	Readju - Corrected Claim	Claim corrected and readjudicated by Alliance. Do not refile.
50	18	Readju - Duplicate Claims	Claim readjudicated by Alliance has already been billed and processed. Do not refile.
51	22	Readju - EOB Required	Claim readjudicated by Alliance. Provider must document primary payor and payment status when refiling claim.
52	125	Readju - Other	Claim readjudicated by Alliance for unspecified reason. Contact Alliance Claims Specialist with questions.
53	22	Readju - Other Primary Insurance	Claim readjudicated by Alliance for other insurance eligibility. Provider must bill to primary insurance. Contact Alliance Claims Specialist with questions.
54	2	Readju - Patient Liability	Claim readjudicated by Alliance to reflect member responsibility. Provider should seek payment from member or responsible party. Contact Alliance Claims Specialist with questions.
55	125	Readju - Provider Billing Error	Claim readjudicated by Alliance to correct billing error. Review adjudication results. Contact Alliance Claims Specialist with questions.
56	125	Readju - Provider ID Incorrect	Claim readjudicated by Alliance to correct provider of service. Review adjudication results. Contact Alliance Claims Specialist with questions.
57	125	Readju - Rate Change	Claim readjudicated by Alliance to process under correct billing rate. Review adjudication results. Contact Alliance Claims Specialist with questions.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
58	123	Overid - Audit Payback	Claim override done by Alliance to effect payback due to audit of services. No action needed.
59	123	Overid - Audit Payback	Claim override done by Alliance to effect payback due to audit of services. No action needed.
60	125	Overid - Audit Recoup	Claim override done by Alliance to effect recoupment of funds due to audit of services. No action needed. Bill any corrected service, if applicable.
61	62	Overid - Authorization/Treatment Revisions	Claim override done by Alliance due to changes in authorization or treatment plan. No action needed.
62	125	Overid - Billing Terms Revised	Claim override done by Alliance due to change in billing terms. Consult contract documents or Alliance website.
63	125	Overid - Contract Terminated	Claim override done by Alliance to reflect end of contract ed provider status.
64	A1	Overid - Corrected Claim	Claim corrected and override done by Alliance. Do not refile.
65	18	Overid - Duplicate Claims	Claim override done by Alliance has already been billed and processed. Do not refile.
66	22	Overid - EOB Required	Claim override done by Alliance. Provider must document primary payor and payment status when refiling claim.
67	62	Overid - Missing/incomplete/invalid treatment authorization code	Claim override done by Alliance due to changes in authorization or treatment plan. No action needed.
68	125	Overid - Other	Claim override done by Alliance for unspecified reason. Contact Alliance Claims Specialist with questions.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
69	22	Overid - Other Primary Insurance	Claim override done by Alliance for other insurance eligibility. Provider must bill to primary insurance. Contact Alliance Claims Specialist with questions.
70	2	Overid - Patient Liability	Claim override done by Alliance to reflect member responsibility. Provider should seek payment from member or responsible party. Contact Alliance Claims Specialist with questions.
71	125	Overid - Provider Billing Error	Claim override done by Alliance to correct billing error. Review adjudication results. Contact Alliance Claims Specialist with questions.
72	125	Overid - Rate Change	Claim override done by Alliance to process under correct billing rate. Review adjudication results. Contact Alliance Claims Specialist with questions.
73	123	Revert - Audit Payback	Claim reverted by Alliance to effect payback due to audit of services. No action needed.
74	123	Revert - Audit Payback	Claim reverted by Alliance to effect payback due to audit of services. No action needed.
75	125	Revert - Audit Recoup	Claim reverted by Alliance to effect recoupment of funds due to audit of services. No action needed. Bill any corrected service, if applicable.
76	62	Revert - Authorization/Treatment Revisions	Claim reverted by Alliance due to changes in authorization or treatment plan. No action needed.
77	125	Revert - Billing Terms Revised	Claim reverted by Alliance due to change in billing terms. Consult contract documents or Alliance website.
78	125	Revert - Contract Terminated	Claim reverted by Alliance to reflect end of contract ed provider status.
79	A1	Revert - Corrected Claim	Claim corrected and reverted by Alliance. Do not refile.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
80	18	Revert - Duplicate Claims	Claim reverted by Alliance has already been billed and processed. Do not refile.
81	22	Revert - EOB Required	Claim reverted by Alliance. Provider must document primary payor and payment status when refiling claim.
82	125	Revert - Other	Claim reverted by Alliance for unspecified reason. Contact Alliance Claims Specialist with questions.
83	22	Revert - Other Primary Insurance	Claim reverted by Alliance for other insurance eligibility. Provider must bill to primary insurance. Contact Alliance Claims Specialist with questions.
84	2	Revert - Patient Liability	Amount denied is the responsibility of the member. No action needed.
85	125	Revert - Provider Billing Error	Claim reverted by Alliance to reflect member responsibility. Provider should seek payment from member or responsible party. Contact Alliance Claims Specialist with questions.
86	A1	Revert - Reverted because reversal/replacement claim has been submitted	Claim reverted to allow reversal or replacement to process. Review adjudication results. Contact Alliance Claims Specialist with questions.
87	2	Adjusted Against Co-Insurance	Claim adjudication reflects member responsibility. Provider should seek payment from member or responsible party. Contact Alliance Claims Specialist with questions.
88	11	Invalid DRG DX Code	Verify DRG diagnosis code and resubmit if billed in error.
89	147	No DRG exists or rate is not set up yet	Verify all DRG information from claim and if billed correctly, contact Alliance Health Claims Research Analyst with questions.
90	48	Non-Covered DRG Services	Services billed under this DRG are not reimbursable. No action needed.
91	199	Invalid Revenue Code	Verify revenue code and resubmit if billed in error.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
92	99	Excess amount over allowed medicare copayment	Claim adjudication reflects coordination of benefits with Medicare and member. Provider should seek payment from member or responsible party. Contact Alliance Claims Specialist with questions.
93	125	Invalid DCN (Document Ctrl #) or resubmission ref #	Verify DCN or resubmission ref # from original claim. Resubmit as replacement/ void.
94	125	Resubmitted claim DOS is after original claim submission date	Resubmit original claim as replacement claim with original DOS.
95	125	Resubmitted claim does not match with the referenced claim	Verify DCN or resubmission ref # from original claim. Resubmit.
96	125	Referenced claims has already been resubmitted. Multiple resubmissions not allowed	No action needed. Contact Alliance Claims Specialist if claim still requires attention.
97	42	Exceeded budgeted amount	Post payment and adjustment. Do not refile.
98	A1	Readju - Denial Rebilling	Duplicate of previously submitted claim.
99	63	Overid - Denial Rebilling	Duplicate of previously submitted claim.
100	125	Invalid date span for discharge claims	Verify dates and resubmit claim.
101	125	Patient does not have a valid Target Pop. on DOS	Verify that member has a valid and current NCTracks Benefit Plan for the date of service billed. Contact Alliance Enrollment and Eligibility for assistance. If no errors exist, do not refile.
102	125	Patient does not have a valid Target Pop. for DX submitted in claim	Verify that member has a valid NCTracks Benefit Plan that corresponds with the diagnosis information on claim. Contact Alliance Enrollment and Eligibility for assistance. If no errors exist, do not refile.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
103	125	Patient does not have a valid Target Pop. for service submitted in claim	Verify that member has a valid NCTracks Benefit Plan for the service billed. Contact Alliance Enrollment and Eligibility for assistance. If no errors exist, do not refile.
104	125	Loaded from legacy system - no reason available	Contact Alliance Health Claims Research Analyst with questions.
105	125	Pended for manual review	Claims staff to manually review claim. Provider can ask for update on manual review status.Contact Alliance Health Claims Research Analyst with questions.
106	125	Pended for COB since patient has no COB record	Provider to update patient COB information in ACS as claim was submitted with COB information. Notify Claims Research Analyst once COB information has been updated. If submitting COB information was a mistake, notify Claims staff so the claim can be denied and provider can resubmit.
107	5	The procedure code/bill type is inconsistent with the place of service.	Provider to contact Claims staff for resolution. Alliance shall verify service and to place of service mapping.
108	31	No coverage available for patient/service/provider combo	Review contract for active service code. Review member's insurance to ensure coverage. Contact Alliance Health Claims Research Analyst with questions.
109	197	Service is not authorized for supplied site	Provider check the site on the authorizaiton - it must match the site on the claim being billed for site-enforced services.
110	22	Revert - Retroactive Medicaid	Ensure that the primary insurance for the patient has been billed and is indicated on the claim being submitted to the MCO.
111	22	Revert - Medicaid coverage	Ensure that the primary insurance for the patient has been billed and is indicated on the claim being submitted to the MCO.
112	A1	Add-on code cannot be billed by itself	Add-on code should be billed on same claim as base code, with the exception of specific psychological testing services. Review submissions. Contact Alliance Health Claims Research Analyst with questions.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
113	B6	The taxonomy code for the billing provider is missing.	Check and confirm that the taxonomy submitted on the claim is associated with the NPI submitted.
114	B6	Missing/Incomplete/Invalid attending/rendering taxonomy code	Contact Alliance Health Claims Research Analyst with questions.
115	47	The diagnosis submitted on the claim is no longer billable or accepted by NC Tracks and will deny at that level.	Check and confirm that the taxonomy submitted on the claim is associated with the attending/rendering NPI submitted.Contact Alliance Health Claims Research Analyst with questions.
116	23	Adjustment represents the estimated amount the primary payer may have paid.	Review diagnosis on claim. Correct claim to refile.
117	22	Override Medicaid Coverage	Primary Payor value must be indicated on claim. Contact Alliance Health Claims Research Analyst with questions.
118	22	Override Retroactive Medicaid	Confirm patient eligibility through Enrollment and Eligibility.
119	133	The disposition of the claim/service is pending further review. (Use only with Group Code OA)	Confirm patient eligibility through Enrollment and Eligibility.
120	45	Amount exceeded allowable COB amount	Claim is under manual review or awaiting arrival of required documentation (EOB or medical records). Contact Alliance Health Claims Research Analyst with questions.
121	185	The rendering provider is not eligible to perform the service billed	Post payment and any adjustment to charges. Do not refile. Contact Alliance Health Claims Research Analyst with questions.
122	MA130	A specific site could not be determined	Verify that site NPI is included in provider profile in ACS. Confirm through Alliance Contracts team prior to refiling claim.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
125	119	Annual frequency exceed	Limit to occurrence of service billable per year. Adjust off charges and do not refile. Only if service is billed in error, file adjusted claim. Contact Alliance Claims Specialist with questions.
127	23	The impact of prior payer(s) adjudication including payments and/or adjustments	Post payment and any adjustment to charges. Do not refile. Contact Alliance Claims Specialist with questions.
128	23	Amount in excess of prior payer(s) coinsurance	Post payment and any adjustment to charges. Do not refile. Contact Alliance Claims Specialist with questions.
129	142	Monthly Medicaid patient liability amount	Claim adjusted for member's PML. Do not refile. Review calculation. Contact Alliance Health Claims Research Analyst with questions.
130	2	Coinsurance amount	Claim adjusted for coinsurance value included on claim. Do not refile. Review calculaton. Contact Alliance Health Claims Research Analyst with questions.
131	119	Quarterly frequency exceeded	Standard frequency limits for quarter have been exceeded. Do not refile. Review utilization. Contact Alliance Health Claims Research Analyst with questions.
132	A1	Invalid Attending Provider for PRTF	Attending Provider NPI listed on claim is not valid for the PRTF named on the claim. Do not refile. Work with Provider Networks to have attending provider added if applicable.
133	96	Non-covered charges due to service in IMD Facility	Charges indicated are not covered. Do not refile. Contact Alliance Health Claims Research Analyst with questions.
134	46	Missing or Invalid CPT/HCPCS Code	Claim does not have valid procedure code indicated. Review claim detail and refile.
135	181	Discontinued Service	Service indicated on claim is not active in provider contract. Review contract detail and work with Provider Network to resolve contract or submit replacement claim if service needs correction.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
136	16	Invalid Units: claimed below minimum amount	Number of units on claim does not meet minimum required by service. Do not refile.
137	16	Invalid Units: units claimed does not equal # of days for Discharge Claim	Number of units on claim does not match with date range on claim. Review units and refile.
138	16	Invalid Units: units claimed does not equal # of days for Interim Claim	Number of units on claim does not match with date range on claim. Review units and refile.
139	31	No effective eligibility exists for the member	Member eligibility not active for date of service on claim. Do not refile. Contact Alliance Health Claims Research Analyst with questions.
140	185	Clinician not associated with Provider	Clinician listed on claim is not associated with Provider agency. Work with Provider Network to add clinician association. Contact Alliance Health Claims Research Analyst to reprocess if clinician becomes associated.
141	59	R&B service already exists - cannot bill another one	Review service for duplication. Contact Alliance Health Claims Research Analyst with questions.
142	16	Invalid or Missing Discharge Code for Discharge Claim	Review discharge code on discharge claim. Make corrections to refile.
143	A8	Ungroupable/Missing DRG	DRG required for service on claim. Make correction and refile.
144	109	Service has lapsed/expired for the contracted site	Service indicated on claim is not active in provider contract. Review contract detail and work with Provider Network to resolve contract or submit replacement claim if service needs correction.
145	59	NCCI - Collective limit for the day exceeded	Limit for service group has been reached. Review other services for the date of service on claim. Do not refile. Contact Alliance Health Claims Research Analyst with questions.

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CLAIM ADJUDICATION CODES AND ACTION			
REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
146	16	Submitting Replacement Provider does not match original Provider	Replacement claim submitted with different provider identified than on original claim. Make corrections. Refile.
147	16	Member ineligble based on age/service/provider type	Member on claim is not within age limits of service provided. Review service requirements. Do not refile. Contact Alliance Health Claims Research Analyst with questions.
148	16	Admit Type and/or Admit Source Missing for Inpatient Claims [FL14-15]	Required data is missing from claim. Review claim and make corrections. Refile.
149	16	Discharge status code missing for Inpatient Claim [FL17]	Required data is missing from claim. Review claim and make corrections. Refile.
150	16	ED member Admitted to Inpatient Facility	ED claim not separately payable when patient submitted to Inpatient Facility
151	16	Assessment or Differed diagnosis period has passed	The service/diagnosis combination is no longer billable for the consumer
152	16	Billing Taxonomy submitted is not associated with the Billing NPI	Provider to validate billing taxonomy submitted on claim is associated with NPI in contract
153	16	Rendering Taxonomy submitted is not associated with the Rendering NPI	Provider to validate rendering taxonomy submitted on claim is associated with NPI in contract
154	16	Clinician Taxonomy submitted is not associated with the Clinician	Provider to validate clinician taxonomy submitted on claim is not associated Clinician im contract
155	16	Admit date is not valid for the bill type	If an interim or discharge inpatient clm is submitted w/an admission date that is greater than the first date of the service on the claim - provider should rebill with the correct information
156	1	Benefit Plan invalid for PC/License Combo	BP does not line up with an active service - provider needs to rebill the claikm w/an active and effective service, BP and license group mapping

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REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
157	45	Adjustment due to COB Allowable Amount	Provider needs to validate primary insurance allowable is correct
158	31	MR claim has service line where a BP cannot be determined	Provider to review the patient's BP status and rebill as needed
159	A1	Site could not be selected based on claim Billing NPI and/or Zip	Provider needs to review information submitted and validate billing NPI and zip code.
160	22	Patient Responsibility (PR) missing from claim	Provider must submit Patient responsibility on claim that is secondary
161	31	Member active in Standard Plan for DOS	Provider needs to validate clients eligibility
162	13	DOS after indicated deceased date for the member	Provider to validate deceased date for the patient.
163	163	Requested documentation not received	Provider to uploade documentation required
164	164	Requested documentation not received timely	Provider did not submit requested documentation withint the timely guidelines
165	250	Incorrect documentation received	Provider sent wrong information - resubmit valid documentation
166	16	MA32 - Missing/incomplete/invalid number of covered days (val code = 80) during the billing period	Provider needs to verify covered dates to the statement period date
167	16	Service requires EVV. Must be submitted through HHAexchange	Provider must submit claim thru the HHA exchange
168	6	Invalid Gender for Service Code	Provider to validate service code to clients gender
169	6	Invalid Gender for Diagnosis	Porovider to validate diagnosis to clients gender
170	6	Invalid or Missing NDC for HCPCS	Provider to review the service and NDC infor on the claim - Rebill as needed

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REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
171	125	Transfer Claim	Provider to review claim status and confirm the D/C status for the patient
172	A8	No Interim Billing for DRG	Provider to ensure the correct bill typs are being submitted on claims and that entire care periods are being billed together
173	31	Member Eligibility Category not Valid for Service	Provider to validate patient category of eligility is valid for the service
174	125	Auto Readjudicate Queue	Claim set for reprocessing by IT as part of system batch.
175	234	Service code is missing the required accompanying service	Provider to rebill the claim with the accompanying service as needed.
176	234	Contract in suspension for Site and/or Service	Provider needs to take necessary action to resolve the contract suspension
186	47	Required secondary diagnosis code not submitted on claim	Provider needs to rebill the claim with a second diagnosis code as needed.
187	256	Not payable based on Primary Payer (COB) adjustment	Provider needs to confirm the correct primary codes were included on the claim
188	125	Pended for COB Adjustment Review	Provider needs to confirm the correct primary codes were included on the claim
190	77	Invalid covered days (value code amount) submitted on the claim	Provider needs to validate the value code and covered days to the statement period
206	311	Annual Exam Date missing or requirement not met for Family Planning Services [1E-7]	Provider needs to ensure that the annual exam date is indicated on the claim
207	59	Collect Service Limits Exceeded for Coverage Policy	Provider needs to refer to the appropriate CCP for collect service limits

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REASON ID	**HIPAA ID**	**REASON DESCRIPTION**	**RECOMMENDED ACTION STEPS**
208	199	The service code billed is invalid for revenue code	Provider needs to ensure that the service code billed is valid for the associated revenue code
209	199	EVV Visit Key is invalid, must be 10 numerical characters	Provider must validate that the EVV visit key code is 10 characters
210	199	Invalid EVV time submitted for DOS	Provider must validate shift times
230	199	Invalid EVV claim submission for DOS. EVV allows one claim per DOS	Provider must submitt multiple shifts in one date on the same claim