EOB Remit Codes

Remit ID	Remit Description
220	{}default message{}
A0626	Authorization Status Manually Set
ABCI	ABCI-Deny base code > 1
ABIL	ABIL-Inappropriate use of bilateral modifier
AC11	AC11-CMO Rebundle
ACCI	ACCI-CCI rebundle
AD11	AD11-Rebundled Service
AD26	AD26-26 Modifier Added
AD50	AD50-Inappropriate use of bilateral modifier
AD51	AD51-51 Modifier Added
ADAN	ADAN-Resubmit with Anesthesia CPT
ADAS	ADAS-Assistant Surgeon not warranted
ADBI	ADBI-Inappropriate use of bilateral modifier
ADCB	ADCB-Global Service previously paid
ADDA	ADDA-Diagnosis inconsistent with patient's age.
ADDI	ADDI-Invalid ICD-9 Code
ADDS	ADDS-Need Individual DOS
ADDU	ADDU-Date Units Mismatch
ADDX	ADDX-Invalid ICD9 diagnosis code for the service reported.
ADEM	ADEM-One E&M/Day/Spec/Dx
ADGA	ADGA-GenAnesNonAnesSpecty
ADGS	ADGS-E&M or supplies within global surgical package
ADIG	ADIG-Added TC or 26 Mod
ADMD	ADMD-Invalid Modifier Code Submitted
ADPC	ADPC-Invalid/Inactive procedure code
ADPM	ADPM-Exceeds procedure maximum allowed per DOS per site.
ADPU	ADPU-Exceeds procedure allowance of one per date of service.
ADSP	ADSP-E/M Codes Same Speclty
ADSU	ADSU-Supply on date of surgical procedure
ADUN	ADUN-Single/unilateral procedure billed >1.
AGDI	AGDI-Diagnosis invalid for gender

EOB Remit Codes

Remit ID	Remit Description
AGDP	AGDP-Service invalid for gender
AID4	AID4-Diag Req 4/5th Digit
ANBC	ANBC-Deny add-on no base code
ANLA	ANLA-MultLineDenNewLnAdd
APNP	APNP-Replace New Patient with Established
APPV	APPV-PreOp/PostOp Visit included in Global Surgical package
ARCC	ARCC-ReplConsultWithEstab
ASLD	ASLD-Level 5 codes require additional documentation.
AXGA	AXGA-XwalkSurgCdToGenAnes
CDG	CDG-Commercial DRG submitted for Medicare member
CNE	CNE-Claim Not Encounter
COB	COB-COB-Overpayment Adjustment
CON	CON-Provider Contract Selection correction
D01	D01-Auto-No fault related
D02	D02-Maximum benefits paid
D03	D03-Work related injury
D04	D04-Benefit not available on date of service
D05	D05-Age restricted benefit
D06	D06-Invalid/missing admission date
D07	D07-After Care Period
D08	D08-Invalid CPT/HCPCS/Rev code for DOS
D09	D09-Assistant Surgeon Not Covered
D10	D10-Patient status invalid for bill type
D101	D101-Primary Diagnosis Required
D11	D11-Rebundled service
D12	D12-Duplicate line on the same claim
D13	D13-Invalid HCPCS for Revenue
D14	D14-Insufficient units for date span
D15	D15-Invalid/Missing Place of Service
D16	D16-Submit medical records
D17	D17-Referral Required

EOB Remit Codes

Remit ID	Remit Description
D18	D18-SSI- Bill Medicaid (UBA)
D19	D19-Unauthorized days not paid
D20	D20-Aetna self-insured
D21	D21-Not CMO bill insurer.
D22	D22-MH-Inpatient Rehab Not Covered
D23	D23-Timely filing exceeded
D24	D24-Authorization denied
D25	D25-EHIP Pricing Error
D26	D26-Procedure description needed
D27	D27-Attending physician required
D28	D28-Discharge status required for inpatient/SNF claims
D29	D29-Duplicate of previously paid claim
D30	D30-Non Covered Contraceptives
D31	D31-Missing discharge hour
D32	D32-Covered days do not match accomodation days
D33	D33-Individual lifetime benefit amount exceeded
D34	D34-Family lifetime unit limit exceeded
D35	D35-Family annual limit exceeded
D36	D36-Individual lifetime visit limit exceeded
D37	D37-Individual benefit limit exceeded
D38	D38-Individual DOS required
D39	D39-Incomplete claim
D40	D40-Medicare non covered DME
D42	D42-Invalid Type of Service
D43	D43-Invalid/missing DRG
D44	D44-Invalid POS for benefit
D45	D45-Non-covered benefit
D46	D46-Provider on pay hold
D47	D47-SNF Not Covered
D48	D48-PT/OT/ST Not Covered
D49	D49-MH Services Not Covered

EOB Remit Codes

Remit ID	Remit Description
D50	D50-IPA termed contract
D51	D51-Prior authorization required
D52	D52-Non Covered Hospice Services
D53	D53-Non IPA - Bill Health Plan
D54	D54-Capitated Coverage
D55	D55-Emergency Requirements Not Met
D56	D56-PCP Benefit
D57	D57-HHC Not Covered
D58	D58-Non Covered Cosmetic Procedure
D59	D59-Non Covered Experimental Procedures
D60	D60-Incorrect Billing Tin
D61	D61-DOS prior to Contract Effective date
D62	D62-Non Covered by Medicaid
D63	D63-Payable under the Vaccines for Children's Program
D64	D64-Specialty Not Certified for Imaging Services
D65	D65-DOS After Contract Termination Date
D66	D66-Behavioral Health Rebundle
D67	D67-Invalid/Missing Required Modifier
D68	D68-Maximum Units Exceeded
D81	D81-Prior authorization has insufficient units remaining.
D85	D85-Service non covered with the diagnosis
D86	D86-Team Surgeon not covered
D87	D87-Co-Surgeon not Covered
D88	D88-Invalid/Missing Condition Code
D89	D89-Invalid/Missing Occurence Code
D90	D90-Hospice submit MCR EOB
D91	D91-UBA Out Of Network Provider
D92	D92-Resubmit to Value Options, PO Box 803, Latham, NY 12210
DAE	DAE-UBA Authorized units exceeded
DAH	DAH-Missing admission hour
DAN	DAN-Resubmit with Anesthesia CPT

EOB Remit Codes

Remit ID	Remit Description
DAPC-1	DAPC-1- Invalid diagnosis code
DAPC-2	DAPC-2- Diagnosis and age conflict
DAPC-3	DAPC-3- Diagnosis and sex conflict
DAPC-5	DAPC-5- E-code cannot be used as principal diagnosis
DAPC-6	DAPC-6- DAPC-6- Invalid procedure code
DAPC-8	DAPC-8- Procedure and sex conflict
DAPC-9	DAPC-9- Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion
DAPC-10	DAPC-10- Service submitted for denial (condition code 21)
DAPC-11	DAPC-11- Service submitted for FI/MAC review (condition code 20)
DAPC-12	DAPC-12- Questionable covered service
DAPC-15	DAPC-15- Service unit out of range for procedure
DAPC-17	DAPC-17- Inappropriate specification of bilateral procedure
DAPC-18	DAPC-18- Inpatient procedure
DAPC-19	DAPC-19- Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present
DAPC-20	DAPC-20- Code 2 of a code pair that is not allowed by NCCI even if appropriate modifier is present
DAPC-21	DAPC-21- Medical visit on same day as a type "T" or "S" procedure without modifier 25
DAPC-22	DAPC-22- Invalid modifier
DAPC-23	DAPC-23- Invalid Date
DAPC-24	DAPC-24- Date out of OCE range
DAPC-25	DAPC-25- Invalid age
DAPC-26	DAPC-26- Invalid sex
DAPC-27	DAPC-27- Only incidental services reported
DAPC-28	DAPC-28- Code not recognized by Medicare for outpatient claims; alternate code for same service may be available
DAPC-29	DAPC-29- Partial hospitalization service for non-mental health diagnosis
DAPC-30	DAPC-30- Insufficient services on day of partial hospitalization

EOB Remit Codes

Remit ID	Remit Description
DAPC-32	DAPC-32- Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days
DAPC-33	DAPC-33- Partial hospitalization claim spans more than 3 days with insufficient number of days meeting PHP services
DAPC-34	DAPC-34- Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria
DAPC-35	DAPC-35- Only mental health education and training services provided
DAPC-37	DAPC-37- Terminated bilateral procedure or terminated procedure with units greater than 1
DAPC-38	DAPC-38- Inconsistency between implanted device or administered substance and implantation or associated procedure
DAPC-39	DAPC-39- Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present
DAPC-40	DAPC-40- Code 2 of a code pair that would be allowed by NCCI if appropriate modifier were present
DAPC-41	DAPC-41- Invalid revenue code
DAPC-42	DAPC-42- Multiple medical visits on same day with same revenue code without condition code G0
DAPC-43	DAPC-43- Transfusion or blood product exchange without specification of blood product
DAPC-44	DAPC-44- Observation revenue code on line item with non-observation HCPCS code
DAPC-45	DAPC-45- Inpatient separate procedures not paid
DAPC-46	DAPC-46- Partial hospitalization condition code 41 not approved for type of bill
DAPC-47	DAPC-47- Service is not separately payable
DAPC-48	DAPC-48-Revenue center requires HCPCS
DAPC-49	DAPC-49- Service on same day as inpatient procedure
DAPC-50	DAPC-50- Non-covered under any Medicare outpatient benefit, based on statutory exclusion
DAPC-53	DAPC-53- Codes G0378 and G0379 only allowed with bill type 13x
DAPC-55	DAPC-55- Non-reportable for site of service

EOB Remit Codes

Remit ID	Remit Description
DAPC-57	DAPC-57- Composite E/M condition not met for observation and line item date for code G0378 is 1/1
DAPC-58	DAPC-58- G0379 only allowed with G0378
DAPC-59	DAPC-59- Clinical trial requires diagnosis code V707 as other than primary diagnosis
DAPC-60	DAPC-60- Use of modifier CA with more than one procedure not allowed
DAPC-61	DAPC-61- Service can only be billed to the DMERC
DAPC-62	DAPC-62- Code not recognized by OPPS; alternate code for same service may be available
DAPC-63	DAPC-63- OT (Occupational Therapy) code only billed on partial hospitalization claims
DAPC-64	DAPC-64- AT (activity therapy) service not payable outside the partial hospitalization program
DAPC-65	DAPC-65- Revenue code not recognized by Medicare
DAPC-66	DAPC-66- Code requires manual pricing
DAPC-67	DAPC-67- Service provided prior to FDA approval
DAPC-68	DAPC-68- Service provided prior to date of National Coverage Determination
DAPC-69	DAPC-69- Service provided outside approval period
DAPC-70	DAPC-70- CA modifier requires patient status code 20
DAPC-71	DAPC-71- Claim lacks required device code
DAPC-72	DAPC-72- Service not billable to the Fiscal Intermediary/MAC
DAPC-73	DAPC-73- Incorrect billing of blood and blood products
DAPC-74	DAPC-74- Units greater than one for bilateral procedure billed with modifier 50
DAPC-75	DAPC-75- Incorrect billing of modifier FB or FC
DAPC-76	DAPC-76- Trauma response critical care code without revenue code 068X and CPT 99291
DAPC-77	DAPC-77- Claim lacks allowed procedure code
DAPC-78	DAPC-78- Claim lacks required radiolabeled product
DAPC-79	DAPC-79- Incorrect billing of revenue code with HCPCS code

EOB Remit Codes

Remit ID	Remit Description
DAPC-80	DAPC-80- Mental health code not approved for partial hospitalization program
DAPC-81	DAPC-81- Mental health service not payable outside the partial hospitalization program
DAPC-82	DAPC-82- Charge exceeds token charge ($1.01)
DAPC-83	DAPC-83- Service provided on or after effective date of NCD non-coverage
DAS	DAS-Admission source required
DAT	DAT-Invalid/missing admission type
DBCA	DBCA-Billed amount exceeds contractual allowance.
DBI	DBI-Not UBA - Bill Insurer
DBID	DBID- Resubmit with the baby's ID number.
DCAT	DCAT-No Reimbursement for Category II or III codes
DCB	DCB-Global Service previously paid
DCMS	DCMS-Per CMS Guidelines, no reimbursement can be made for these services.
DCON	DCON-Consult codes invalid per CMS. Please rebill with an E&M code.
DCRP	DCRP-Case Rate payment previously paid for DOS
DCUST	DCUST-Authorization Denied. Custodial Level of Care is not covered.
DCV	DCV-Covered by NYS and NYC Child Vaccine Program
DD50	DD50-Invalid Bilateral modifier
DDA	DDA-Other coverage disallowed
DDDS	DDDS-Need Individual DOS
DDI	DDI-Invalid ICD-9 Code
DDIG	DDIG-Added TC or 26 Mod
DDS	DDS-DOS after discharge
DDSU	DDSU-Supply on date of surgical procedure
DDUC	DDUC-CPT Paid with 50 Mod
DDX	DDX-Invalid ICD9 diagnosis code
DDXP	DDXP-Invalid diagnosis code for service billed
DE1	DE1-Contact Health Plan for Accupuncture Benefits
DE10	DE10-Services Not Considered Medically Necessary

EOB Remit Codes

Remit ID	Remit Description
DE11	DE11-Non Covered Vision Services
DE16	DE16-Non Covered In Vitro Fertilization
DE2	DE2-Non Covered Blood Products
DE3	DE3-Contact Health Plan for Chiropractic Benefits
DE32	DE32-Non Covered Transportation
DE33	DE33-Non Covered Hearing Services
DE4	DE4-Non Covered Cosmetic Procedures
DE40	DE40-Services Non Covered by Medicare Guidelines
DE41	DE41-Provider Specialty invalid for this type of service
DE42	DE42-Payable by Medicaid Fee for Service
DE43	DE43-VAMC Claim - Medicare Member
DE44	DE44-VAMC Claim - Medicaid Member
DE6	DE6-Dental Services are not covered - Bill the Member's Dental Carrier or the Health Plan/Insurer
DEB	DEB-Submit primary eob
DER	DER-E/R paid at global rate
DFD	DFD-DOS indicated not valid/incorrect
DFEE	DFEE-Fee Not on File
DFV	DFV-Scanning Error Correction
DGA	DGA-GenAnesNonAnesSpecty
DGDI	DGDI-Diagnosis invalid for gender
DGDP	DGDP-Service invalid for gender
DHP	DHP-Health Plan responsibility
DHS	DHS-Hospice related services
DIAD	DIAD-IAD Payable by Medicare
DID4	DID4-Diag Req 4/5th Digit
DINV	DINV-Please submit a paper invoice for this service to CMO Special Handling Unit.
DIPC	DIPC-Invalid ICD9 Procedure Code
DIR	DIR-Additional information required
DLA	DLA-Local Anesthesia not covered
DMH	DMH-Non- medical benefit (UBA)

EOB Remit Codes

Remit ID	Remit Description
DMHE	DMHE-Mental Health Coding Denied
DMOD	DMOD-Please submit anesthesia modifier code(s)
DMOM	DMOM-Resubmit with the Mother's ID
DMP	DMP-Submit Medicare EOMB
DMR	DMR-Member responsibility
DNBC	DNBC-Deny add-on no base code
DNCD	DNCD-Service non-contracted for the date of service
DNCP	DNCP-Procedure Code Not Covered
DNCS	DNCS-Non contracted service
DNEG	DNEG-Negotiated rate
DNM	DNM-Non- MH benefit (UBA)
DNP	DNP-Non covered provider
DNPE	DNPE-No provider eligibility
DNST	DNST-SurgTrayDeny-NoValCd
DOC	DOC-Other Covg Possible
DOM	DOM-Service not authorized, OON provider (UBA)
DOP	DOP-Please submit operative report
DOS	DOS-Date of Service correction
DOSE	DOSE-Non-covered for reasons other than statutory exclusion.
DOTR	DOTR-Outpatient treatment report required (UBA)
DPBP	DPBP-Payment being processed
DPD	DPD-Claim being processed by Plan under Member's Part D Benefit
DPEC	DPEC-Pre-existing condition
DPER	DPER-Pre-existing research
DPN	DPN-Invalid provider, name required
DPP	DPP-Paid by health plan
DRA	DRA-MemReassignforMBCIPA
DRB	DRB-Units/days exceed admission days
DRC	DRC-Invalid revenue code
DRF	DRF-Routine foot care
DRGT	DRGT-ReplaceGlob/TechComp

EOB Remit Codes

Remit ID	Remit Description
DRP	DRP-Rollover pay not due (UBA)
DRR	DRR-UBA referral required
DSAN	DSAN-CMS Sanction Period
DSED	DSED-SED Carveout, Bill State (UBA)
DSP	DSP-Please submit paper claim
DST	DST-Provider settlement
DTB	DTB-Invalid type of bill
DTI	DTI-Anesthesia Time Required
DTIN	DTIN-Provider TIN not active for DOS
DTR	DTR-Non covered transportation
DUP	DUP-Services provided by unlicensed provider
DVC	DVC-Invalid Value Code
DX	DX-Diagnosis Code correction
EB	EB-Primary EOB submitted, pay as secondary
ENC	ENC-Encounter Not Claim
EXO	EXO-Exclusion Override
HAF	HAF-Half Reassignment - MBCIPA
ICO	ICO-IntelliClaim rule override
IIS	IIS-Incorrect information submitted on the original claim
M0016	M0016-Non-covered benefit
M0200	M0200-Non-covered benefit
MDG	MDG-Medicare DRG submitted for Commercial member
MOD	MOD-Modifier correction
NOPR	NOPR-Denied NOPR. Bill Medicare.
OP	OP-Op Report/Proc. Description Received
OTR	OTR-No OTR Received - MBCIPA
PCP	PCP-PCP Paid as SCP in error
POS	POS-Place of Service correction
PRO	PRO-Procedure Code correction
R07	R07-Claim Denied
REA	REA-Reassignment - MBCIPA

EOB Remit Codes

Remit ID	Remit Description
REV1	REV1-Deductible/Coinsurance amount(s) incorrect
REV2	REV2-Incorrect Provider/Group paid
REV3	REV3-Co-payment amount(s) incorrect
REV4	REV4-Balance Billing on Out of Network service
REV5	REV5-Corrected Bill Submitted
REV6	REV6-Procedure code inconsistent with patient's age
REV7	REV7-Procedure code inconsistent with patient's sex
REV8	REV8-CCMS Auth updated after claim process date
REV9	REV9-Diagnosis inconsistent with patient's age
REV11	REV11-HP Rate Received Retroactively
REV12	REV12-HP Provided Incorrect Rate
REV13	REV13-IPA Contracted Rate Received Retroactively
REV14	REV14-Manual Pricing Error Correction
REV15	REV15-Member Eligiblity updated
REV17	REV17-Duplicate claim - previously denied
REV18	REV18-Duplicate claim - previously paid
REV19	REV19-HP Audit Error Correction
REV20	REV20-CMO Quality Audit Error Correction
REV22	REV22-Benefit maximum has been reached
REV23	REV23-Benefit Information received from HP incorrect
REV30	REV30-Denial reversed per Medical Review
REV31	REV31-Claim denied in error
REV32	REV32-Claim paid in error
REV33	REV33-Claim paid to incorrect address
REV34	REV34-Stop-pay issued. Claim reprocessed
REV35	REV35-Claim denied as duplicate. Not a duplicate.
REV36	REV36-Over/Under payment adjustment
REV37	REV37-Check Voided. Claim(s) reprocessed
REV38	REV38-No Auth/Referral required
REV39	REV39-Receipt Date Entered Incorrectly
REV40	REV40-Provider Information Updated

EOB Remit Codes

Remit ID	Remit Description
REV41	REV41-COB Information updated
REV42	REV42-Medicare Secondary Payer Adjustment Amount
REV43	REV43-Auto-related injury/No-Fault
REV44	REV44-Workers Compensation case
REV45	REV45-Other coverage primary
REV46	REV46-Reversal - Member Appeal
REV47	REV47-Retroactive receipt of referral
REV48	REV48-Incorrect Member/ID Selected
REV49	REV49-Reversal - Provider Appeal
REV50	REV50-IPA termed contract
REV51	REV51-EHIP Pricing Error
REV52	REV52-Compliance with Bill 8417
REV53	REV53-Cash Receipt Refund
REV54	REV54-Bioscript RX Cancellation
REV55	REV55-CMO is Primary
REV56	REV56-Admission/visit cancelled
REV57	REV57-Full recoupment of initial payment. Payment adjustment will follow on this or a future eob.
REV58	REV58-VA Recoupment
REV59	REV59-HSR Credit Balance
REV60	REV60-Hospice CMO Not Primary
REV61	REV61-COB Systemic Reversal
REVAIS	REVAIS-Auth in system when claim was processed
SCP	SCP-SCP Paid as PCP Encounter
SY	SY-System Modification Error
TFA	TFA-Timely Filing - Administrative decision
TFD	TFD-Timely Filing - Documentation received
TOS	TOS-Incorrect TOS selected
UGLOB	UGLOB-Professional services part of behavioral health facility fee
UNI	UNI-Units Correction