

EOB Code

Code Description

001 Possible COB - Worker Comp
002 Possible COB - Auto Accident
003 Possible COB - Other Accident
004 Possible COB - Military Service
00Z Pricer - No errors
01A Optimizer - Error Accessing Payor File
01D Optimizer - Error accessing PAYER file
01Z Pricer - No available APC/fee schedule rate
020 Member temp not eligible
021 Member did not pay
022 Member pend (Reserve)
023 Member pend (Reserve)
024 Member pend (Reserve)
025 Member pend (Reserve)
02A Optimizer - Error Accessing Hospital Rate File
02D Optimizer - Error accessing rate calculator file
02Z Pricer - Invalid HCPCS code
03A Optimizer - Missing Rate Calculator Record
03D Optimizer - Missing rate calculator record
03Z Pricer - Invalid payment status
04A Optimizer - Error Loading Grouper
04D Optimizer - Error accessing Grouper program
04Z Not Covered Under OPPS
05A Optimizer - Error Loading Pricer
05D Optimizer - Error accessing Pricer program
05Z Pricer - Reserved for invalid units
06A Optimizer - No Rates Available for DRG
06D Optimizer - No rates or weights (no matching record)
06Z Pricer - Missing/invalid fee schedule type
07A Optimizer - Error Accessing Rate/Weight File
07D Optimizer - Error accessing rate or weight file
07Z Pricer - Co-payment out of valid range
08A Optimizer - Reserved.
08D Optimizer - Reserved.
08Z Pricer - Invalid modifier for pricing
092 Member's last name is not the same between claim and membership
093 Member's first name is not the same between claim and membership
094 Member's middle name is not the same between claim and membership
095 Member's date of birth on the claim does not match membership record
096 Member's gender is not the same between claim and membership
09A Optimizer - Reserved.
09D Optimizer - Error opening Grouper or Pricer in batch mode
09Z Pricer - Packaged service
100 Unknown Member
101 Subscriber not actively enrolled on service date
102 Member not actively enrolled on service date
103 Illegal assignment_type in Member History
105 No coverage during service period
106 Coverage change during service period
107 Family must have benefit_plan assign in Family_History
108 Benefit not covered for spouse
109 Benefit not covered for dependent
10A Optimizer - Reserved.
10D Optimizer - Error opening ACE report file
10Z Pricer - Line item denial or rejection from ACE
110 Provider not in Provider Master
111 Professional not in Provider Master
112 Unknown Professional Specialty
113 Professional is not allowed to submit UB_92 form
114 Insured group does not match enrolled record
115 Payer ID not found
116 Unknown Form Type
117 Missing Claim in UB Table
118 Missing Claim in Claim_Header Table
119 Unknown Provider Type
11A Optimizer - Error Loading Editor
11D Optimizer - Error loading Editor program
11Z Pricer - Invalid units for this modifier
120 Missing Claim in Claim_Detail Table
121 COB Claim

122 COB Claim must have paid_by_primary_payer information
123 Member has double coverage, only COB claims are going to be paid
124 This is COB claim for a member who does not have double coverage
125 Unknown COB payment method
126 Paid by primary payer can not be negative amount
127 EOB code not found - check log
128 Will reconsider upon submission of Primary Carriers Explanation of Benefits. Denied
129 Will reconsider upon submission of Primary Carriers Explanation of Benefits. Pend
12A Optimizer - Non-Zero Return from Editor
12D Optimizer - Non-zero return code from Editor program
12Z Pricer - Incorrect coding of lab panel components
130 Submit to Cofinity for Repricing
131 Allowed amount is zero.
13A Optimizer - Non-Zero Return from Grouper
13D Optimizer - Non-zero return code from Grouper program
13Z Pricer - ZIP code missing or invalid, for ambulance fee schedule service only
140 Required member network id for the selected plan type
14A Optimizer - Non-Zero Return from Pricer
14D Optimizer - Non-zero return code from Pricer program
14Z Pricer - Device intensive procedure without device
15A Optimizer - Invalid Date or From Date > Thru Date
15D Optimizer - Reserved.
15Z Invalid units for revenue code
16A Optimizer - Invalid Operation Code
16D Optimizer - Invalid value for OPCODE1
16Z Medically unlikely edit
170 Service date after receive date
171 Date of service before date of birth
174 Interim billing
17A Optimizer - Invalid Patient Type
17D Optimizer - Invalid value for PATTYPE
17Z Service billed as panel
18A Optimizer - Outpatient Claim Contains Unacceptable Errors
18Z Invalid units for modifier
190 Service date outside of UB Statement Covers From/Thru dates
191 No valid benefit plan in group benefit for subscriber attributes in family history
192 Benefit_plan according to the group_benefit has already expired
193 Incorrect deductible from date in relation to benefit effective date or benefit
194 Unknown benefit plan ID in family history
199 Pend after adjudication was requested
19Z Payment included in composite rate
200 Unknown ICD9 code - Please resubmit with a HIPAA valid ICD9 code
201 Additional digit is required for this ICD9 code
202 Unknown CPT code - Please resubmit with a HIPAA valid CPT code
203 Inactive CPT code - Please resubmit with a HIPAA valid CPT code
204 Unknown Modifier - Please resubmit with a HIPAA valid Modifier
205 Failed to assign Ben_Cat
206 Multiple Ben_Cat_id assigned
20Z Incorrect billing of Telehealth site fee
212 Unspecified cot code - XXX99 - Please resubmit with a more specific code and/or a
21Z Item paid at a user-defined percent of charges
22Z Contractor priced item requires additional setup for reimbursement
231 Missing Claim in HCFA_1500

232 Prov_id is not Facility type
233 Prof_id is not Professional type
234 Member deductible definition in benefit payment detail ext for ben_cat included
235 Member max_pocket definition in benefit payment detail ext for ben_cat included
236 Family deductible definition in benefit payment detail ext for ben_cat included
237 Family max_pocket definition in benefit payment detail ext for ben_cat included
238 Member max_allowed definition in benefit payment detail ext for ben_cat included
239 Member max_encounters definition in benefit payment detail ext for ben_cat
23A Optimizer - From Date is After Through Date
240 Family max_allowed definition in benefit payment detail ext for ben_cat included
241 Number of steps in Benefit Payment 2 is incorrect
242 Number of steps in Benefit Payment 2 is incorrect(Plan Deductible)
270 Authorization is required for this service
271 No proper auth has been obtain by provider or member. copayment amount in case o
272 No proper auth has been obtain by provider or member. percent allowed in case of
273 No auth has been obtained by provider or member.allowed amount is limited to max
274 Forced pend provider
300 Unlisted code - Please resubmit using a more specific code and/or a description of
301 Payment Reduced by Deductible Amount
302 A copayment has been applied to this service
303 A coinsurance has been applied to this service
304 Reduced paid by provider percent_of_allowed
305 Reduced paid by percent_allowed after out_of_pocket is met
306 Payment adjusted based on modifier submitted
314 Reduced paid by provider withhold
317 This type of contract will pay only last claim (see bill_type)
319 Claim Denied for authorization reasons
320 contract not found
321 Fee schedule contract not found
322 No fee schedule for service code (ucr_fees)
323 Percent Billed Contract not found
324 Capitation Contract not found
325 Global_fee contract not found
326 Per_diem contract not found
327 Reduced Amount BY MAX Allowed
328 Per_Admit Contract not found
329 Grouper Contract not found
330 No authorization number present in claim header
331 Individual out of pocket limit for benefit year is met
332 Copay has already been taken for this visit.
333 Family lifetime max limit is met
334 Family out of pocket limit for benefit year is met
335 Individual lifetime out of pocket limit is met
337 Family lifetime out of pocket limit is met
338 Number of copayment met.
343 Exceeded max allowed amount for claim
344 Member annual allowed amount exceeded max
345 Annual allowed amount for ben_cat exceeded max
346 Member lifetime allowed amount exceeded max
347 Number of visits exceeded max
348 Family annual allowed amount exceeded max
350 Individual life max for benefit category exceeded max
351 Family life max for benefit category exceeded
352 Family annual allowed amount for benefit category exceeded max
353 Unknown Payment_Type for BEN_CAT
354 Unknown contract type
355 Benefit_plan not found in Benefit_Payment_Master
356 Ben_cat not covered in benefit_plan
357 Member age excludes benefit coverage
358 Ben_cat will take effect after number of days specified in benefit_plan_payment
359 Business rules are not fulfill in benefit_payment_detail
360 Dependent age limitation in this plan
361 Student age limitation in this plan
362 Missing COBRA information
363 Service date is after COBRA termination date
364 Performed service is not part of contract which will be paid under global_fee_co
365 This service is still within days_after from range in this global_fee_contract,
366 Global_fee_accumulator has been updated with a new event_date
367 Remaining portion will not be paid, since this is max amount which can be covered
368 Subscriber enrolled in Cobra, will keep his or her ID.
371 Contract required to use professional index
372 Contract required to use provider index

373 Index unknown, use index = 1.0
375 Unknown payment assignment
376 Submitted DRG not same as the Calculated DRG
377 Grouper interface failed
378 This type of contract can not be given to professional provider
379 Discharge hour is required on UB 92 form
381 Standard UCR rate
382 Special rate have been used for this procedure (cpt fees)
383 Standard Medicaid Fee Schedule
384 No fee schedule for service code (Medicaid Fee Schedule)
386 Possible COB
388 Possible COB - Multiple Coverage
389 Outpatient per case contract with provider
390 UB per line item contract with provider
391 Payment is fee schedule based
392 Percent billed contract with provider
393 Capitation contract with provider
394 Global_fee contract with provider
395 Payment Based on Per Diem Rate
396 Inpatient Per_admit contract with provider
397 Grouper contract with provider
398 DRG contract with provider requires DRG code be present on UB92 form
399 HCFA payment by service code per day/claim
400 No Provider Contract
401 Provider Contract for not specific ben_cat
402 Standard Network Contract
403 No Provider Contract, default Network arrangement is use
404 No Network Contract
405 Insurance_Product does not have default network assign
406 Add NDC AWP payment
407 Code not in Fee Schedule.
408 No PCP Contract
409 Provider Contract for specific ben_cat
410 Not paid because of capitation contract
411 Lower allowed amount by Rebundler percentage
413 Payment can not be made to professional_id = NULL
414 Allowed amount reduced because of multiple ASC surgery grouping
415 Default contract has not been defined
416 Additional charges have been applied.
417 Paid by additional charges.
418 Schedule amount exceed Billed amount; Pay billed amount.
419 Additional charges charges will not be paid since the total allowable amount is
431 Preexisting conditions
450 Authorization not found
451 Authorization given to different member
453 Admit day is outside authorized admission time frame
454 Discharge day is outside authorized discharge time frame
455 Authorization has not been approved
456 Authorization has been denied
457 Accident date not present
500 Denied by Rebundler
501 New Line Item
502 Duplicate Line Item
503 Assistant Surgeon limit exceeded for this procedure
504 reduced paid according to rebundler rule
505 Possible Duplicate
509 Pended by Rebundler
510 Rider Option selected
511 Rider Option - Number visits exceed max
512 Reduced paid by discount amount
528 Age is out of range for the given Primary Diagnosis
529 Gender is invalid for the given Primary Diagnosis.
530 Age is out of range for the given code
531 Sex code is invalid for the given CPT
532 Pend the given Modifier code
533 MODIFIER NOT CONSIDERED ELIGIBLE BY SIGNATURE CARE - PROV W/O
534 Amount exceeds the general parameter pend amount
535 Anesthesia base unit is not listed
536 Claim missing type of service
537 Missing provider category (provider/professional)
538 Stop Loss amount reached
539 Claim being denied over filing limit

540 Total charges not equal to total charges of line items
599 Manual Pended
600 Manual overwrite
601 Manual Payment
602 Manual Denied
603 Manual Pend
604 OOC force payment
605 Inappropriate Coding
606 Primary Carrier EOB Required
607 Not A Covered Benefit
608 Denied - No Medical Coverage
609 Denied - No Dental Coverage
60A \$1500 Benefit Maximum Met
610 Denied - No Vision Coverage
611 Duplicate Claim
612 Eligibility Documentation Required (i.e.. Birth Certificate. Marriage License. Divorce
613 Exceeds filing limit - Can Not Bill Patient
614 Require Other Insurance Information
615 Denied Incidental Procedure
616 Exceeds 60 Days Of Date On Primary EOB-Can't Bill Patient
617 Invalid/Deleted Diagnosis Code
618 Invalid/Deleted Procedure Code
619 Medical Records Must Be Submitted
620 Other Insurance Information Required
621 Part of Global Code
622 ER Review - Denied by Medical Director
623 Prior/After UR Authorized Dates
624 Denied - Over Plan Filing Limit
625 Unlisted Procedure - Submit Supporting Documentation
626 Not A Billable Service By This Provider
627 Pending for Cobra Election/Monthly Premium Payment
628 Denied-Service Exceeds Plan Limit
629 Charges Incurred After Term Date
630 Duplicate line item
631 Claim Exceeds Authorized Visits
632 Denied - No UR Authorization
633 Diagnosis Does Not Match Authorized Diagnosis
634 Penalty - No Out Of Network Authorization
635 Inappropriate Place Of Service Billed
636 Itemized Statement Required
637 Denied Related To Workmans Comp
638 Provider Not Properly Credentialed
639 Paid As Secondary
640 Charges Incurred Prior To Effective Date
641 Requested Information Received
642 Require Copy Of Operative Report
643 Pending For Medicare Effective Date
644 Age Is Out Of Range For Given CPT
645 Incorrect Patient Demographics
646 Require Attending Physicians Name
647 Denied Requested Information Not Received
648 Required Description of Primary's Remark Codes
649 Pend for ER Review
650 Pend for MM Review
651 Charges Applied to Deductible
652 This Is A Predetermination
653 Patient Pays - ID Card Not Shown
654 Exceeds Lifetime Ortho Maximum
655 Submit Original Primary EOB
656 Maximum Pay Amount. Patient Owes Balance
657 Resubmit With Anesthesia Code/Modifier
658 Total Anesthesia Minutes Required
659 Exceeds Yearly Dental Maximum
660 Historical Claim Adjustment
661 Requested Information Received Greater Than 90 days. Patient Responsibility
662 No Review of Appeals Outside of 6 Months From Date of Service
663 No Secondary Consideration Until Primary's Request Satisfied
664 Require Primary Carrier's EOB
665 Student Status Information Required
666 Split Claim Needed for Non Covered Charges
667 Require Facility Name Where Services Were Rendered
668 EOB and Claim Do Not Match

669 Item Paid Up To Purchase Price, No Addtl Payment
670 Denied For Split For Year End
671 Waive 120 Days-Proof of Filing
672 Not Included In Case Rate
673 Resubmit- illegible EOB
674 Split Payment Due To Benefits
675 RX Payable Thru Drug Carrier Only
676 Require Copy of Birth Certificate
677 Require eligibility verification form
678 Require Copy of Marriage License
679 Require Copy of Birth Certificate and Divorce Decree/Court Order
680 Require Copy of Birth Certificate and Marriage License
681 Require Copy of Divorce Decree/Court Order and Marriage License
682 Manually Repriced
683 Non-Network Provider
684 Denied by Medical Director after Review
685 Covered In Contracted Case Rate
686 Per primary carrier EOB, This is a provider write-off
687 Denied-Exceeds annual maximum benefit limit
688 Provider ineligible/provider write-off
689 Submit to Cofinity for Pricing
690 Non Emergent Ambulance Dx
691 Not a THC Enrollee
692 Resubmit with a THC referral
693 Resubmit with Prenatal Dates
694 Invalid Place of Service
695 Not covered by Medicaid
696 Service Included
697 Previously paid
698 Capitated Service
699 Service not authorized on referral
700 Payment thru plan deductible
701 Number of visit per year exceed max
702 Adjust Allowed amount to amount per visit max.
703 Claim exceeds days since accident (EOB)
704 Claim exceed EOB max pay amount
705 Payment is according EOB formula
706 Benefit reduced by plan deductible
707 Accident(EOB) occurred after service date
708 Missing accident date for accident related claim
709 Contract configuration/setup is invalid
710 Class configuration/setup is invalid
711 Claim had been paid at header level
712 Cannot find insurance product ID for a given benefit plan
713 Fee Schedule configuration/setup is invalid
714 Visit definition is set to 'Day'; service from date is not equal service to date
715 This visit has been paid.
717 Denied - Empl/Auto Accident claim or Military service related
71A Optimizer - Payor/Payout Record Error
725 Conflict services between main class and additional class
726 Minimum % OF billed applied.
72A Medcalc/Medout Record Error
73A Optimizer - Rate/Rateout Record Error
74A Optimizer - No Weights
750 Submitted DRG is not same as Calculated DRG (3M)
790 Contract is not active
791 OP Default contract is not defined
792 IP Default contract is not defined
800 Payer pend action
802 Professional pend action
803 Provider pend action
808 DRG fee schedule pend action
809 DRG_COMM schedule pend action
810 Anesthesia base unit schedule pend action
811 Anesthesia cross walk schedule pend action
812 Anesthesia fee schedule pend action
813 General fee schedule pend action
814 Home infusion schedule pend action
815 NDC schedule pend action
816 RBRVS schedule pend action
817 OP RVU schedule pend action
818 UCR rate schedule pend action

819 HCFA contract pend action
81A Optimizer - Payor/Payout File Error
820 OP per case contract pend action
821 OP per item contract pend action
822 IP per admit pend action
823 IP per diem pend action
824 Global contract pend action
825 Medicaid schedule pend action
826 Medicaid sub schedule pend action
827 less than % of premium before release
828 Ambulatory Service Centers payment pend
829 Pend code based on code history
82A Optimizer - Medcalc/Medout File Error
830 Exceed maximum allowed time for pended claim - Denied
831 IP per item contract pend action
832 IP grouper contract pend action
833 OP grouper contract pend action
83A Optimizer - Rate/Rateout File Error
84A Optimizer - Fee Schedule File Error
850 Applied iCES edits
851 Pend based on iCES edits
852 Denied based on iCES edits
853 iCES - Interface failed
88A Optimizer - Initialization Error
88D Optimizer - Initialization error
89A Optimizer - Memory Allocation Error
89D Optimizer - Error allocating memory
900 Benefit Payment Copay Order (Deductible/Copay)
901 Benefit Payment Copay Order (Copay/Deductible)
90A Optimizer - Invalid Request
910 PCP is required, but member not assigned PCP
911 Change description later - PCP logic
912 Pay according to Professional general contract
913 Pay according TO PCP contract
914 Professional IS NOT IN PCP's coverage pool
95A Optimizer - Parameter Error
95D Optimizer - Parameter passing error
96A Optimizer - Server Response Exceeds Maximum Length
97A Optimizer - Worksheet Not Available
98A Optimizer - Invalid Outpatient Classification
99A Optimizer - Optimizer Not Found
99D Optimizer - Unable to load Optimizer
AA0 Authorization Class does not match
AA1 Authorization - LOS does not match
AA2 Authorization - Discharge does not match
AA3 Authorization - Professional does not match
AA4 Authorization - unit exceeded
AA5 Authorization - visit exceeded
AA6 Authorization - exclusion
AA7 Authorization - Service Modifier does not match
AA8 Authorization - Location does not match
AA9 Copayment paid per service day
AB0 Authorization - Service code does not match
AB1 Authorization - Member Network ID does not match
AB2 Authorization not obtain within allow timeframe
AB3 Authorization - claim denied because service is not included
AC1 Visit falls before the event period.
AC2 Visit: Anchor date is being denied or pended.
C18 Inv Use of Modifier-Prov W/O
F01 Member not eligible
F02 No saving claims history
F03 Member did not pay
F04 Reduced Paid
F05 Invalid Group
F06 Invalid Flex Plan
F07 Invalid HRA Plan
F08 Full payment
F09 Normal payment
F29 Available amount less than claim amount
F30 Full payment type
F31 Normal payment type
F32 Assumed report type

F33 Real payment report type
F34 Employer pay first
F35 Roll over payment
F36 Paid by roll over
F37 Paid by HRA
F38 Paid full payment by HRA
F39 Paid portion by employer deduction
F40 Full payment by employer deduction
F41 Paid portion by employee deduction
F42 Full payment by employee deduction
F43 Paid by employee deduction first
F70 Same problem with account
P22 Testing Provider Pend Code
R02 Repriced Claim - Invalid payer setup
T01 PCP claim not serviced by member's PCP: pend. change Action to 'I' to bypass this
T02 Physician in PCP's coverage pool; Use PCP's contract.
T04 Physician in PCP's pool but use different network: Use PCP's contract. network.
TPD TVZ paid/denied
XXX Visit falls before the event period.