PAYMENT REASON CODES

CAO	169 Alternate benefit has been provided.
CON	Contracted provider discount. Claim repriced through Consilium. Please refer to the specific network code for inquiries.
CPW	Public Event worked, COVID test.
ER	Emergency service provided by a Non-Network provider paid at the benefit level of a Network provider.
LCS	This plan has no member cost-sharing for any item or service that is an Essential Health Benefit when furnished directly by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.
OOC	Service provided outside of the United States.
P01	Procedure code does not have a Medicare allowable.
P02	Per CMS Guidelines, reimbursement is based on lesser of the fee schedule or billed charges.
P03	This Procedure code indicates that multiple therapy services were performed. Per CMS, a reduction of practice expense component applies for this line.
P04	Payment for Procedure code is always bundled into payment for other services not specified and no separate payment is made, per Medicare.
P05	RVU status indicator M (Measurement codes). Used for reporting purposes only.
P06	This procedure code indicates that multiple surgery services were performed. Per CMS, a reduction applies for this line.
P07	Per Medicare's Medically Unlikely Edits Policy, total units billed for procedure code exceeds the allowed units.
P08	Medicare considers Procedure code as a bundled service when other payable services are billed on the same day by the same provider.
P09	Procedure code is an unlisted procedure or service.
P10	This procedure code qualifies for a multiple endoscopy reduction and payment should be reduced by value of the base endoscopy code.
P11	Items and services packaged into APC rates.
P12	Per Medicare's Medically Unlikely Edits Policy, the units of service billed for this procedure exceed the allowed units.
P13	Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present.
P14	Code not recognized by Medicare for outpatient claims; alternate code for same service may be available.
P15	This service is not appropriate for Medicare patients in an ambulatory surgery center setting.
P16	Per CCI Guidelines, Procedure Code has an unbundled relationship with another Procedure Code.
P17	This Procedure code indicates that multiple diagnostic radiology services were performed. Per CMS, a reduction applies for this line.
P18	HCPCS/CPT indicates this service is for COVID-19.
P19	COVID-19 HCPCS/CPT vaccine should be billed to your local MAC.
P20	Revenue center requires HCPCS.
P21	Procedure code indicates that multiple diagnostic cardiovascular services were performed. Per CMS, a reduction applies for this line.
P22	Per Medicare Guidelines, Procedure Code is bundled with an all-inclusive ambulance service.
P23	Multiple observations overlap in time (inactive).
P24	Observation revenue code on line item with non-observation HCPCS code.
P25	COVID-19 HCPCS/CPT is only allowed to be reimbursed on a UB-04 Claim.
P26	MPPR. This Procedure code indicates that multiple diagnostic ophthalmology services were performed. Per CMS, a reduction applies for this line.
P27	Code not recognized by OPPS; alternate code for same service may be Available.
P28	Procedure Code requires a crosswalk to an anesthesia code prior to editing. Replace the surgical CPT code with the appropriate anesthesia code.
P29	Invalid diagnosis code
P30	Procedure code is not reimbursed by OPPS; an alternate procedure code crosswalk was applied.
P31	Non-covered under any Medicare outpatient benefit, based on statutory exclusion.
P32	HCPCS/CPT indicates service is for COVID-19 vaccine.
PCC	State Primary Care Clinic Payment.
PCE	Non-covered due to PCC service incurred at Non-PCC clinic. Exception approved by Sanford.
SP	Specialist services provided by a Non-Network provider paid at the benefit level of a Network provider.
T0P	Tier 1 related professional charge
T1B	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
T1E	Tier 1 Service authorized for normal plan benefit.
T1H	Tier 1 service incurred with Non-Tier 1 facility/ provider, higher out of pocket applied.
T1I	Tier 1 qualified service was incurred as inpatient. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
T1O	Tier 1 qualified service was incurred as outpatient. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
T1P	Preventive benefit applied, allowed at 100%. This service is Tier 1 incurred at Non-Tier 1 facility, future claims for this service at Non-Tier 1 level will incur higher out of pocket if preventive benefit is not available.
T2P	Tier 1 related professional charge
T3P	Tier 1 related professional charge
TBE	Tier 1 Service authorized for normal plan benefit.
TBH	Tier 1 service incurred with Non-Tier 1 facility/provider, higher out of pocket applied.
TBP	Tier 1 related professional charge
TCE	Tier 1 Service authorized for normal plan benefit.
TCH	Tier 1 service incurred with Non-Tier 1 facility/provider, higher out of pocket applied.
TCI	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.

PAYMENT REASON CODES

TCO	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
TCP	Tier 1 related professional charge
TDE	Tier 1 Service authorized for normal plan benefit.
TDH	Tier 1 service incurred with Non-Tier 1 facility/provider, higher out of pocket applied.
TDO	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
TGE	Tier 1 Service authorized for normal plan benefit.
TGH	Tier 1 service incurred with Non-Tier 1 facility/provider, higher out of pocket applied.
TGO	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
TGP	Tier 1 related professional charge
TKE	Tier 1 Service authorized for normal plan benefit.
TKH	Tier 1 service incurred with Non-Tier 1 facility/provider, higher out of pocket applied.
TKI	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
TKO	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
TME	Tier 1 service authorized for normal plan benefits. Qualified Preventive services allowed at 100%.
TMH	Tier 1 service incurred with Non-Tier 1 facility/provider. Tier 1 Preventive services allowed at 100% benefit. Higher out of pocket applied to additional Tier 1 non-preventive service.
TNR	Payable at Normal Plan Benefits
TOE	Tier 1 Service authorized for normal plan benefit.
TOH	Tier 1 service incurred with Non-Tier 1 facility/provider, higher out of pocket applied.
TOI	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
TOO	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
TSC	Tier 1 qualified service was incurred. This charge considered as part of the tier 1 procedure. Payment issued to primary facility per contract.
UN	Non-Network hospital based physician services provided at a contracting facility.
01	Charge exceeds the maximum allowable or usual, customary, and reasonable (UCR) amount.
02	Charges previously processed, refer to your prior Explanation of Benefits statement.
04	Preauthorization required but not obtained. Unable to determine Medical Necessity. Please contact the provider of service and request that they contact our Medical Service Department for payment consideration.
05	This dental service is not covered.
07	Charges should have been submitted to a Workers' Compensation carrier.
08	This charge has been paid or is payable by another carrier.
10	This nonprescription drug is not covered.
14	Preauthorization/notification required but not obtained.
15	This service, supply, or appliance is not covered.
16	This service is prior to the effective date of coverage based on the member identification number provided on the claim form submitted. If you feel this denial is in error, please notify the provider and request that the claim be resubmitted with the appropriate member identification number.
17	This service is after termination of coverage based on the member identification number provided on the claim form submitted. If you feel this denial is in error, please notify the provider and request that the claim be resubmitted with the appropriate member identification number.
18	This person is not covered.
19	Provider not covered.
20	This routine vision service or supply is not covered.
21	Pre-existing waiting period has not been met.
23	This therapy service or supply is not covered.
24	Information necessary to process this charge was requested and not received.
25	This cosmetic related service is not covered.
26	This weight reduction service is not covered.
28	Services, supplies, or medications for the diagnosis or treatment of alcoholism, substance abuse, chemical dependency, tobacco addiction, or co-dependency treatment are not covered.
30	Since the deductible has not been met, no coordination of benefits applies on this claim. Once the deductible has been met, coordination of benefits will apply.
38	Services for social adjustments are not covered.
40	Physical, psychiatric, or psychological examinations or testing, vaccinations, immunizations, treatments, or testing for purposes of obtaining or maintaining employment, insurance, or relating to camp, school or athletic physicals are not covered.
41	Claim exceeds the timely filing period for submission.
42	Coverage was not effective for this service at the time it was rendered.
49	This conception service is not covered.
50	Response was not received to a refund request made on a previously processed claim(s). This amount is being applied to an outstanding refund request.
51	Refund has been requested as another insurance carrier is primary. An Explanation of Benefits from the primary carrier is required for processing.
55	Treatment for military service connected disabilities are not covered.
61	No coverage/contract in force based on the member identification number provided on the claim form submitted. If you feel this denial is in error, please notify the provider and request that the claim be resubmitted with the appropriate member identification number.
62	This food, food supplement or special diet is not covered.
63	The purchase price for this item has been met.

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64 Member has no obligation to pay this amount since the provider agreed to charge no more for this service/supply than the negotiated rate.
71 There is a payment limitation for this benefit.
73 This service was performed by a non-participating provider.
81 This routine service is not covered.
82 Charges for medical records are not covered.
87 The plan reimburses up to the semi private room rate.
88 Patient convenience items, tax, phone calls, mailing fees and guest meals are not covered.
91 Brand name drug dispensed when generic required.
93 Disposable items are not covered.
99 Elective sterilization procedures are not covered.
101 This drug is not covered in the Formulary.
102 This orthotic service or supply is not covered.
103 Biofeedback is not covered.
107 Criteria for the orthodontia benefit has not been met.
108 Payment of benefits for orthodontic treatment will be made in installments every 90 days during the course of treatment. If treatment will exceed two years, benefits will be made in eight equal installments.
110 Services for experimental or investigational procedures, drugs or research studies are not covered.
111 TMJ services and supplies are not covered.
112 Yearly dental maximum has been reached.
113 Orthodontia lifetime maximum has been reached.
115 Prior authorization not obtained from Health Management Partners.
117 Routine oral exam and prophylaxis are limited to once every six months.
118 Services and supplies listed as excluded or not specifically listed as covered under the plan are not covered.
119 This is the patient's responsibility after Integration of Benefits.
122 This claim is being adjusted. Charges will be reprocessed under a new claim.
124 Charges connected with an intentional self-inflicted bodily injury are not covered.
126 Dependent child maternity services are not covered.
132 Transplant network services, member has no obligation to pay this amount.
138 Injuries which occur while under the influence of illegal drugs or alcohol are not covered.
143 Member has no obligation to pay this amount since the provider agreed to charge no more for this service/supply than the negotiated rate.
144 Claim processed using the PreferredOne provider network.
147 This amount represents a Subrogation recovery.
148 Contraceptives are not covered.
149 Waiting period for this procedure has not been met.
151 These pharmacy charges must be submitted to Express Scripts, Inc. (ESI) for processing. Please contact ESI at 866-272-9858 for a claim form.
157 Medical payment coverage is primary. If that coverage has been exhausted, a copy of the medical payment insurer's detailed payment log is required to reprocess this claim.
159 Charges are being reprocessed under a new claim number.
160 Services for an illness or injury incurred by a Member engaged in the commission of a crime are not covered.
161 This charge must be submitted to the pharmacy carrier.
165 This charge exceeds the number of fluoride treatments allowed in the benefit period.
166 Fluoride application denied due to age limitation.
168 These charges are being denied because an itemized claim was not provided.
172 Provider of service must submit this claim to PreferredOne.
175 Charges exceed Medicaid/Medicare reimbursement.
180 Non-formulary medication dispensed.
182 Provider of service must submit this claim to the HealthSmart provider network.
183 Claim processed using the HealthSmart provider network.
185 The pharmacy has reversed these charges.
188 No coordination of benefits applies since no payment was made by the primary insurance carrier.
189 This charge must be submitted to the primary pharmacy carrier.
190 This plan is primary. Pharmacy charges must be submitted here first to be eligible for processing.
191 Medical review determined that this service was not medically necessary or not supported by the diagnosis given and payment will not be made. Participating providers may not bill this service to the member.
192 Claim processed using the Chiropractic Associates, Ltd. of South Dakota (CASD) provider network.
193 Provider of service must submit this claim to the Chiropractic Associates, Ltd. of South Dakota (CASD) provider network.
194 ACH (direct) deposit payment. Date paid to member is the date the payment was sent to the financial institution. The payment will be deposited into the account on the following business day.
195 General, routine health exams (including annual physicals and sports or employment-related physicals) are not covered.
196 Claim processed under the vision benefit.
198 Yearly vision maximum has been reached.
201 This claim must be submitted through the appropriate South Dakota Department of Health Program. Please resubmit with the correct client identification number.
202 This is a duplicate to a charge we are currently processing.
205 These charges are not related to claimed Workers' Compensation injury.
212 According to the SD Department of Labor, the maximum charge allowable for the copies of provider records is ten dollars for the first ten pages and thirty-three cents for each additional page.
215 Prior authorization not obtained. For payment consideration, contact Health Management Partners at www.preauthonline.com or 1-866-330-9886.

PAYMENT REASON CODES

216 No documentation or medical records provided which support these charges.

219 Charges for service/supply/report not approved by Workers' Compensation.

220 Workers' compensation claim processed by Precision Bill Review (PBR) according to state guidelines and applicable PPO contract. For additional information, please refer to the PBR Explanation of Review provided under separate cover. If you need further assistance, please contact PBR at 605-362-5673.

240 Service for injury or disease arising out of or in the course of any work for pay or profit is not covered.

242 Provider of service must submit this claim to the Midland's Choice provider network.

243 Claim processed using the Midland's Choice provider network.

244 Contracted provider discount, repriced by A&G.

250 Claim submitted to A&G, no discount obtained.

251 This amount has been applied to the member's pharmacy deductible.

252 This service was previously paid as Well-Care in this Benefit Period.

264 Claim processed using the Healthcare Preferred provider network.

265 Benefits were coordinated with the health plan.

266 Services are not considered within the scope of practice of this provider.

267 We have received information that you may have other health insurance. Please contact our Coordination of Benefits Department.

268 Claim processed on behalf of the Wise Women Program.

269 Claim processed on behalf of the All Women Count Program.

270 Charges should have been processed as Workers' Compensation.

273 Claim processed using the Presbyterian Select provider network.

274 Chiropractic Associates, Ltd. of South Dakota (CASD) Utilization Review.

275 Charges not authorized by Workers' Compensation.

276 Indemnity check was voided and reissued.

278 These charges have been routed for processing under the dental benefit.

279 These charges have been routed for processing under the vision benefit.

281 Orthopedic Institute employee/dependent, claim filed in error.

282 Claim processed using the Private Healthcare Systems (PHCS) Healthy Directions network.

283 HealthLink negotiated fee applied, patient has no obligation to pay this amount; the ineligible column on the Provider Detail Statement is not billable to the patient.

284 Provider of service must submit this claim to HealthLink provider network.

286 Charges not covered. Provider is non-participating with your primary insurance carrier.

287 These charges are currently under review. When a determination has been made by the Workers' Compensation Administrator, these charges will be processed accordingly.

288 Claim submitted to Private Healthcare Systems (PHCS) Healthy Directions, no discount obtained.

290 MultiPlan discount applied. Patient is responsible for the difference between the MultiPlan amount and the amount paid by the plan.

301 Curascript Injectable Program must be utilized in order to receive full benefit for this medication. Please contact Curascript at 1-800-278-0980.

302 We have submitted this prescription charge to Express Scripts, Inc. for processing. Please submit future pharmacy claims directly to Express Scripts, Inc. at Mail Route # BLO470, P.O. Box 390873, Bloomington, MN 55439-0873.

303 This charge will be processed on a separate claim under the pharmacy benefit.

304 We have determined that we are the secondary payer and are requesting a full refund. Receipt of an Explanation of Benefits from the primary carrier is required for reprocessing of this claim.

305 Refund received. An Explanation of Benefits from the primary carrier is required for reprocessing.

306 We will reprocess as secondary payer upon receipt of an Explanation of Benefits from the primary carrier.

307 The type of bill, place of service and/or type of service were not billed as authorized.

308 We will reprocess as secondary payer upon receipt of a corrected Explanation of Benefits from the primary carrier.

311 Provider charge reversal due to submission/billing error(s).

318 Anesthesia charges must be submitted with the surgical CPT and appropriate modifier for the South Dakota Risk Pool Plan.

319 This is the patient's responsibility after Carve-out Coordination of Benefits.

321 Patient does not meet age or gender guidelines for this service.

322 This fee has previously been paid to another provider.

323 Please resubmit with the appropriate forms for the All Women Count! Program.

324 Does not meet All Women Count! cervical cancer screening policy.

326 These professional services must be billed on a HCFA form.

328 Benefits reduced or denied as charges incurred as a result of engaging in an unsafe practice or hazardous hobby.

329 We will process these charges upon receipt of the Medicare and/or Medicare Supplement Explanation of Benefits.

330 Any amount listed as ineligible or discount is the amount over the allowable fees as determined by the State of South Dakota Legislation for members in the South Dakota Risk Pool Plan.

331 We have received a copy of the primary health plan's Explanation of Benefits. A copy of the claim is required for processing as secondary payer.

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336 Service is not covered by All Women Count. These charges may not be billed to the member.

337 Payment denied. Supporting documentation either inaccurate or incomplete. Please resubmit correctly. For further clarification please contact 605-773-6031.

338 Patient does not match date of birth. Please submit corrected claim to our office.

339 Patient does not match date of birth. Please submit corrected claim to our office.

342 We are unable to process this claim as the Type of Bill is missing, incomplete or invalid. Please resubmit the claim with the correct code and Claim Inquiry Form for payment consideration.

343 We are unable to process this claim as the Type of Bill is missing, incomplete or invalid. Please contact the provider of service and request that they resubmit a corrected claim with the correct code.

350 We will not pay an amount the primary plan did not cover because the rules and procedures were not followed accordingly.

351 Billed charges on claim must match the Explanation of Benefits.

355 Our records indicate this patient has either other primary health, dental or vision coverage. A copy of the Explanation of Benefits is required for processing of this claim.

356 Information regarding the accident questionnaire is required for processing of this claim. Please contact our Subrogation Department.

375 Charges exceed Medicaid/Medicare reimbursement.

400 Description, documentation or medical records are required before this charge can be considered for reimbursement.

401 Description, documentation or medical records are required before this charge can be considered for reimbursement. Please notify the provider and request that the claim be resubmitted with a description of this charge.

402 Claims for Cardiac Rehabilitation Services require phase type and number of units to process. Please resubmit this claim and include this information.

404 Medical necessity has not been established for this service or supply and/or the level of care is not appropriate for the diagnosis and/or condition.

407 The type of bill, place of service and/or type of service were not billed as authorized.

411 Provider charge reversal due to submission/billing error(s).

414 Preauthorization/notification required but not obtained.

415 Prior authorization not obtained. For payment consideration, provider must contact Health Management Partners at www.preauthonline.com or 1-866-330-9886.

416 Preauthorization required for this injection/medication but not obtained. Unable to determine Medical Necessity. For payment consideration, provider must contact the Medical Service Department.

421 Medical records are required in order to substantiate reimbursement for the CPT modifier associated with this service. Please notify the provider of service and request that the claim be resubmitted with supporting medical records.

422 Mental health services, supplies, or medications not specifically listed as covered under the plan are excluded.

423 Services for disorders in which the main symptoms are caused by, or in response to, exposure to common life stressors of a non-medical origin; marital relationship problems; social, marital or occupational maladjustment; and gambling addiction are excluded.

424 Coverage has been provided for the first 48 or 96 hours of inpatient care for this newborn child. In order to extend this coverage, application must be made within the timeframes outlined in the Member Handbook and dependent eligibility requirements must be met.

425 Claim represents processing of non-enrolled newborn Facility charges.

428 Services, supplies, or medications for the diagnosis or treatment of tobacco addiction or co-dependency treatment are not covered.

429 Services, supplies, or medications related to nondependent substance use disorders are not covered.

438 Charges must be filed with Medicaid/Medicare.

439 The noncovered amount represents the penalty for not obtaining preauthorization/notification.

440 Brand formulary medication dispensed.

441 Information received outside timely filing.

450 Pharmacy Copayment.

452 This amount is not eligible due to a discount arrangement with the patient's primary insurance carrier. Neither the patient nor the secondary payer is responsible for this amount.

453 Examination, treatment or testing which is received pursuant to an order or judgment issued by a court, administrative or regulatory body is an exclusion of the contract.

454 This service or supply is listed as an exclusion of your plan.

455 Payment denied due to absence of an Employee Assistance Plan referral.

456 This service or supply is not covered under the chiropractic benefit of the plan.

457 This vision service or supply is not covered under your plan.

459 This dental service or supply is not covered under your plan.

460 Claim processed under the Freedom Dental benefit.

463 The purchase price for this item has been met.

464 Please contact the Subrogation Department if another payer (Workers' Compensation, auto insurance, other) is responsible for payment of this claim.

471 There is a payment limitation for this benefit.

482 Charges for medical records are not covered.

483 This claim has been reviewed and does not qualify for the Major Injury Protection benefit.

484 To complete the required Health Assessment and avoid reduction in benefit, please go to

PAYMENT REASON CODES

www.liveforlife.net/hfit/sd to complete online or contact the Bureau of Human Resources toll free 1-877-573-7347 or Pierre local number 773-3148.

485 This service was not rendered at a State preferred provider. Additional member responsibility is applied.

486 A 10% benefit reduction has been imposed. To avoid future benefit reductions you must complete the required Health Assessment. Please go to www.liveforlife.net/hfit/sd to complete online or contact the Bureau of Human Resources toll free 1-877-573-7347 or Pierre local number 773-3148.

487 We are unable to process this claim as the incorrect ICD version/Indicator is being used for this date of service or diagnosis code or diagnosis pointer is missing, incomplete or invalid. Please notify the provider and request that the claim be resubmitted with proper coding.

488 We are unable to process this claim as the CPT/HCPCS or REVENUE code is missing, incomplete or invalid. Please notify the provider and request that the claim be resubmitted with proper coding.

489 We are unable to process this claim as the CPT modifier code is missing, incomplete or invalid. Please notify the provider and request that the claim be resubmitted with proper coding.

490 Our records indicate this member had other coverage in effect at the time this service incurred. Due to plan provisions coverage is not available for this date of service. Please contact the Bureau of Human Resources (605-773-3148) if this information is not accurate.

491 We have received your corrected claim; however, we cannot reconsider this charge until a Claim Inquiry Form including supporting medical records is provided.

492 Individual charges must balance with total charge. Please notify the provider and ask that the claim be corrected and resubmitted.

493 Individual charges must balance with total charge.

494 We have received an inquiry regarding this charge; however, we are unable to reconsider this charge as the information provided does not support the need for modification of the original payment.

495 Professional health care services provided by a relative are not covered.

496 These maternity services are not covered as conception occurred prior to the effective date of the policy.

497 This claim has been processed at the out-of-network benefit level. For In-network benefit consideration, an out of area authorization is needed. Please advise your referring physician to contact Health Management Partners at 1-866-330-9886.

499 This claim has been processed at a reduced benefit level. Requests for out-of-state services are declined if the patient care can be provided safely and cost effectively in South Dakota.

501 One or more of the submitted codes does not comply with generally accepted coding practices and has been denied. Some denied codes may be eligible for reconsideration of payment if the coding is modified and the claim is resubmitted.

502 Charges paid by medical payment coverage.

504 Medical necessity has not been established for this service or supply and/or the level of care is not appropriate for the diagnosis and/or condition.

505 There is an exclusionary rider to your Policy which excludes services, supplies, and/or treatment for this condition.

506 This amount has been applied to your maternity copayment.

507 Nutritional or vitamin profiles, products, and testing as commonly associated with complementary or alternative medical therapy are not covered.

508 Claim processed using the First Health Network.

509 Claim submitted to First Health, provider is non-contracting.

510 Claim processed on behalf of the KOMEN foundation.

511 Claim processed using the WISE network.

512 Claim submitted to Micron Health Partners and WISE Networks, provider is non-contracting.

513 This service has been processed according to your wellness care program.

514 This service or supply is not covered according to the provisions of your accident only excess benefit plan.

515 Claim has been processed according to the provisions of your accident only excess benefit plan.

516 In accordance with coordination of benefit rules, this claim was processed using the secondary plan's contracted discount as it was greater. Neither the patient nor the secondary plan is responsible for this amount.

517 Eligible charges were applied to your Well-Care benefit.

518 Eligible charges were applied to your Cancer Screening benefit.

519 Eligible charges were applied to your Routine/Preventive Care benefit.

520 There is no coordination of benefits provision for pharmacy benefits.

521 Medical records are required in order to substantiate reimbursement for this CPT modifier.

522 This amount has been applied to your annual orthodontic deductible.

523 This amount has been applied to your lifetime orthodontic deductible.

524 Telehealth medicine technology is not a reimbursable service. This is an ineligible charge and should not be billed to the patient.

525 Eligible orthodontic services are reimbursed in quarterly installments. Our records indicate that an installment payment is not due at this time.

526 Prior authorization not obtained. For payment consideration, provider must contact the Medical Services Department.

527 We are unable to process this claim as outpatient charges billed within 72 hours of an inpatient stay to treat the same illness, should be billed with the inpatient charges.

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528 Claim processed using the Micron Health Partners Network.

530 This plan requires the enrollee to be a resident of South Dakota. Upon confirmation of valid address, this claim would be eligible to be reconsidered. Member, please contact the Plan Administrator at 1-605-773-3148.

531 Services performed by a non-contracting provider. Payment for these services will be mailed to you on the date indicated above. You are responsible to pay the provider of service directly.

532 Service is not consistent with professionally recognized standards of health care.

533 This amount has been applied to your maternity deductible.

535 If you have dental coverage, please contact your dental carrier.

536 Claim processed on behalf of the National Breast Cancer Foundation (NBCF).

537 The well-care limit has been met for this benefit year. Charges in excess of the limit have been applied toward the medical benefit.

538 Received Medicaid/Medicare EOB. Claim will be processed through the Hutterian Health Fund.

539 $500 of the plan savings amount represents the penalty for not obtaining prior authorization.

540 Charge is not allowable due to the provisions of the South Dakota Risk Pool.

546 Claim processed on behalf of the SD Colorectal Screening Program.

550 Claim submitted to Consilium, no savings obtained.

551 These pharmacy charges must be submitted to CVS Caremark for processing. Please contact CVS Caremark at the toll free number provided on the back of your member ID card to obtain a claim form.

552 We have submitted this prescription charge to CVS Caremark for processing. Please submit future pharmacy claims directly to CVS Caremark at P.O. Box 52136, Phoenix, AZ 85072-2136.

553 Claim processed using the First Choice of the Midwest provider network.

554 Claim submitted to First Choice of the Midwest, provider is non-contracting.

555 These services were considered under your medical coverage. Charges may be eligible to coordinate under a dental plan. If you have dental coverage, please contact your dental carrier for possible coordination.

556 Claim processed on behalf of South Dakota Dept of Health.

557 Claim processed on behalf of the American Breast Cancer Foundation.

560 Services for disorders which involve delinquency or behavior are excluded.

565 Provider of service must submit this claim to the appropriate Transplant Network.

570 Charges reviewed for inappropriate billing and/or incomplete documentation and/or Usual, Customary & Reasonable charges by Resource Protective Services. Reductions applied are listed in the ineligible column on the Provider Detail Statement and the patient is not responsible for the amount listed in this column. If you have additional information to substantiate any of these charges or any questions related to these reductions, please contact Resource Protective Services at 800-686-4035.

571 Lifetime maximum benefit has been met.

573 Services provided by a non-participating provider are subject to a penalty reduction in benefits.

574 Charges reviewed for incomplete documentation by Resource Protective. Reductions applied are listed in the ineligible column on the Provider Detail Statement and the patient is not responsible for the amount listed in this column. If you have additional information to substantiate any of these charges or any questions related to these reductions, please contact Resource Protective Services at 800-686-4035.

575 Charges reviewed for inappropriate billing by Resource Protective Services. Reductions are listed in the ineligible column on the Provider Detail Statement and the patient is not responsible for the amount listed in this column. If you have additional information to substantiate any of these charges or any questions related to these reductions, please contact Resource Protective Services at 800-686-4035.

576 Charges reviewed for Usual, Customary & Reasonable charges by Resource Protective Services. Reductions are listed in the ineligible column on the Provider Detail Statement and the patient is not responsible for the amount listed in this column. If you have questions, please contact Resource Protective Services at 800-686-4035.

581 We have received your corrected claim; however, we cannot reconsider this charge until a claim including supporting medical records is provided.

583 This claim has been reviewed and does not qualify for the Hospital Indemnity Program.

587 We are unable to process this claim as the incorrect ICD version/Indicator is being used for this date of service or diagnosis code or diagnosis pointer is missing, incomplete or invalid. Please resubmit the claim with proper coding.

588 We are unable to process this claim as the CPT/HCPCS or REVENUE code is missing, incomplete or invalid. Please resubmit the claim with proper coding.

589 We are unable to process this claim as the CPT modifier code is missing, incomplete or invalid. Please resubmit the claim with proper coding.

590 We are unable to process this claim as the date(s) of service are missing, incomplete or invalid. Please resubmit the claim with the valid date(s) of service.

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591 We are unable to process this claim as the date(s) of service are missing, incomplete or invalid. Please resubmit the claim with the valid date(s) of service.

610 Payment based on a contractual amount or agreement, fee schedule or maximum allowable amount.

618 Eligible charges were applied under the Health & Lifestyle Condition Management benefit.

622 This fee has been previously paid.

623 This amount has been applied to your lifetime TMJ deductible.

624 According to your plan benefits, criteria for this service has not been met.

628 For payment consideration, provider must contact the Medical Services Department to establish medical necessity.

629 For payment consideration, provider must contact the Medical Services Department to establish medical necessity.

630 Description is required before this charge can be considered for reimbursement. Please provide NDC and/or drug description (including strength) along with quantity.

631 Description is required before this charge can be considered for reimbursement. Please provide NDC and/or drug description (including strength) along with quantity. Please notify the provider and request that the claim be resubmitted with a description of this charge.

632 Claim processed using the Beechstreet Network.

633 Claim submitted to Beechstreet, provider is non-contracting.

635 Class I, Class II, Class III, Market or Medical Device Safety recalls or withdrawals ordered or requested by the United States Food and Drug Administration (FDA), or recalls or market withdrawals taken by a firm to remove its product from the market are not covered.

640 Records necessary to process this claim requested from the Provider were not received.

641 Records necessary to process this claim received from the Provider were incomplete.

642 Health History Questionnaire requested from the Member was not received.

643 Health History Questionnaire received from the Member was incomplete.

644 This fee has been previously paid to another provider.

645 This amount has been applied to your emergency room copayment.

646 Discounts were taken in accordance with provider's agreement with IPN.

647 Claim submitted to Idaho Physicians Network (IPN), provider is non-contracting.

650 One or more of the submitted codes does not comply with generally accepted coding practices and has been denied. Some denied codes may be eligible for reconsideration of payment. For reconsideration, please notify the provider and request that the coding be reviewed and resubmitted if appropriate.

651 These pharmacy charges must be submitted to SelectHealth for processing. Please contact SelectHealth at 800-442-3127 for a claim form.

652 We are unable to process this claim as the Place of Service is missing incomplete or invalid. Please resubmit the claim with the correct code and Claim Inquiry Form for payment consideration.

653 We are unable to process this claim as the Place of Service is missing incomplete or invalid. Please contact the provider of service and request that they resubmit a corrected claim with the correct code.

659 Prior authorization not obtained. For payment consideration, contact Health Management Partners at 1-866-330-9886.

660 Requires authorization of services. Please contact DAKOTACARE Medical Services to initiate authorization.

661 The oncology services provided do not match approved services.

662 Oncology treatment exceeds authorized timeframe approved.

663 Requires authorization of services. Please have your provider contact DAKOTACARE Medical Services to initiate authorization.

664 The oncology services provided do not match approved services.

665 Oncology treatment exceeds authorized timeframe approved.

666 Claims for Erythropoietin Stimulating Agents require Hemogloblin levels for the dates of service. Please fax these lab values to DAKOTACARE pharmacy department at 605-274-3279 so these claims may be reviewed for payment.

667 Claims for Erythropoietin Stimulating Agents require Hemoglobin levels for the dates of service. Please have your provider fax these lab values to DAKOTACARE pharmacy department at 605-274-3279 so these claims may be reviewed for payment.

668 Hemoglobin levels were reviewed and did not meet medical necessity for reimbursement.

669 Hemoglobin levels were reviewed and did not meet medical necessity for reimbursement.

670 Charges reviewed by Resource Protective Services and reductions were applied. These reductions are reflected in the Plan Savings column of your Explanation of Benefits. Patient is not responsible for the amount listed in this column at this time. However, if the provider submits additional information and the charges are substantiated, there may be additional patient responsibility. Any questions related to these reductions should be referred to Resource Protective Services at 800-686-4035.

671 Member has no obligation to pay this amount per Resource Protective Services negotiated rate.

675 Special contracted rate applied including ancillary related charges. Refer to total line on EOB for final calculation of benefit.

679 Per provider contract, a copy of supplier invoice is needed for reimbursement of surgical implants.

680 Per the contracted rate, this charge is considered as part of the primary procedure. Payment is issued to the primary facility.

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681 This charge falls under a bundled contracted service. Per contract, benefits are payable to the surgical facility.

682 If you have vision coverage, please contact your vision carrier.

683 These services were considered under your medical coverage. Charges may be eligible to coordinate under a vision plan. If you have vision coverage, please contact your vision carrier for possible coordination.

688 Claim processed using the InterWest network.

689 Provider of service must submit this claim to InterWest provider network.

690 We are unable to process this claim as there is no WORK COMP First Report of Injury on file.

700 The disposition of the claim/service is pending further review.

701 Discount granted through the TLC Advantage Network.

702 Claim not billed per facility contract. Facility to review and resubmit. Charges subject to reprocessing.

704 Medical necessity has not been established for this service or supply. Please contact Health Management Partners at 1-866-330-9886 or www.preauthonline.com to supply documentation.

705 Preauthorization managed care review by Health Management Partners of South Dakota deemed this service not medically necessary and is not covered by the Plan.

706 Prior authorization is required but not obtained for this medication. For payment consideration, provider must access www.dkc-pa.com to initiate authorization.

707 RAS is now the Workers' Compensation Administrator for State of South Dakota. Please submit claims to Payor ID LS368. RAS Claims Support: 1-877-585-1117, PO Box 89310, Sioux Falls, SD 57109.

708 Prior authorization is required but not obtained for this medication. For payment consideration, provider must access www.dkc-pa.com to initiate authorization.

710 This claim item is currently considered investigational and is ineligible for payment. Providers may not bill this amount to the member.

711 We are unable to process this claim as the taxpayer identification number (TIN) is missing, incomplete or invalid for this date of service. You may not bill the patient pending correction of your TIN. Please resubmit this claim after you have notified this office of your correct TIN.

712 We are unable to process this claim as the taxpayer identification number (TIN) is missing, incomplete or invalid for this date of service. The provider may not bill the patient pending correction of the TIN. Please have the provider resubmit this claim after they have notified this office of the correct TIN.

713 We are unable to process this claim as the attending physician or facility National Provider Identifier (NPI) is missing or incomplete. Please resubmit this claim after you have notified this office of your NPI.

714 We are unable to process this claim as the attending physician or facility National Provider Identifier (NPI) is missing or incomplete. Please have the provider resubmit this claim after they have notified this office with the NPI.

716 In accordance with coordination of benefit rules, this claim was processed using the secondary plan's contracted discount as it was greater. Neither the patient nor the secondary plan is responsible for this amount.

719 Provider not covered.

720 For SD residents, the mandatory tobacco cessation interventions and tobacco products may be obtained through the SD Quitline 1.866.SD-QUITS (1-866-737-8487) or www.SDQuitline.com.

721 For MN residents, the mandatory tobacco cessation interventions and tobacco products may be obtained through QUITPLAN 1-888-354-PLAN (7526) or www.quitplan.com.

730 Weight at the time of administration is needed to process this medication.

731 Weight at the time of administration is needed to process this medication.

732 This service may be transplant related and has been processed under your medical benefits.

735 This charge considered as part of the service/procedure provided.

737 Provider was not certified to be paid for this service.

740 This patient has other insurance. Please review all Explanation of Benefit forms for this claim to determine the patient responsibility due.

742 Provider Agreement not on file. Please contact All Women Count at 1-800-738-2301.

743 Single Case Agreement in place. Repricing needed. Provider of service should refer to and follow agreed upon Single Case Agreement for correct claims repricing procedure. The member has no obligation to pay this amount.

744 Benefit approved under individual case management.

751 This portion of the copay is reimbursable by the manufacturer. Does not apply to member's OOP or Flex.

752 Transplant Case Rate Applied

765 Provider of service must submit this claim to OptumHealth Managed Transplant Program. Please call OptumHealth at 1-800-367-4436 for assistance.

770 Claim paid Discount Program amount.

800 Charges must be submitted on the appropriate HCFA or UB form to be considered for claims processing.

801 We are unable to process this claim as the credentialing process for the attending practitioner has not been completed with DAKOTACARE. The practitioner may not bill the patient. The claim will need to be resubmitted to DAKOTACARE once the credentialing process has been completed.

802: The charge(s) for this service was processed in accordance with Federal/State Balance/Surprise Billing regulations. As such, any amount identified with OA, CO, or PI cannot be collected from the member and may be considered provider liability or be billable to a subsequent payer. Any amount the provider collected over the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. Payment amounts are eligible for dispute following any Federal/State documented appeal/grievance/arbitration process.

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803: The Federal No Surprise Billing Act Qualified Payment Amount (QPA) was used to calculate the member cost share(s).
804: Alert: The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute following the Federal documented appeal/grievance/dispute resolution process.
001 Invalid diagnosis code.
002 Diagnosis and age conflict.
003 Diagnosis and sex conflict.
004 Medicare secondary payer alert.
005 E-diagnosis code cannot be used as principal diagnosis.
006 Invalid procedure code.
007 Procedure and age conflict (inactive).
008 Procedure and sex conflict.
009 Non-covered under any Medicare outpatient benefit, for reasons other than statutory exclusion.
013 Separate payment for services is not provided by Medicare.
014 Code indicates a site of service not included in OPPS.
015 Service unit out of range for procedure (inactive).
016 Multiple bilateral procedures without modifier 50.
017 Inappropriate specification of bilateral procedure.
018 Inpatient procedure.
019 Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present.
020 Code2 of a code pair that is not allowed by NCCI even if appropriate modifier is present.
021 Medical visit on the same day as a type T or S procedure without modifier 25.
022 Invalid modifier.
023 Invalid date.
024 Date out of OCE range.
025 Invalid age.
026 Invalid sex.
027 Only incidental services reported.
028 Code not recognized by Medicare for outpatient claims; alternate code for same service may be available.
029 Partial hospitalization service for non-mental health diagnosis.
030 Insufficient services on day of partial hospitalization.
031 Partial hospitalization on same day as ECT or type T procedure.
032 Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days.
033 Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services.
034 Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria.
035 Only Mental Health education and training services provided.
036 Extensive mental health services provided on day of type T procedure.
037 Terminated bilateral procedure or terminated procedure with units greater than one.
038 Inconsistency between implanted device or administered substance and implantation or associated procedure.
039 Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier was present.
040 Code2 of a code pair that would be allowed by NCCI if appropriate modifier were present.
041 Invalid revenue code.
042 Multiple medical visits on same day with same revenue code without condition code G0.
043 Transfusion or blood product exchange without specification of blood product.
044 Observation revenue code on line item with non-observation HCPCS code.
045 Inpatient separate procedures not paid.
046 Partial hospitalization condition code 41 not approved for type of bill.
047 Service is not separately payable.
048 Revenue center requires HCPCS.
049 Service on same day as inpatient procedure.
050 Non-covered under any Medicare outpatient benefit, based on statutory exclusion.
051 Multiple observations overlap in time (inactive).
052 Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions.
053 Codes G0378 and G0379 only allowed with bill type 13x or 85x.
054 Multiple codes for the same service.
055 Non-reportable for site of service.
056 E/M condition not met and line item date for obs code G0244 is not 12/31 or 1/1.
057 Composite E/M condition not met for observation and line item date for code G0378 is 1/1.
058 G0379 only allowed with G0378.
059 Clinical trial requires diagnosis code V707 as other than primary diagnosis.
060 Use of modifier CA with more than one procedure not allowed.
061 Service can only be billed to the DMERC.
062 Code not recognized by OPPS; alternate code for same service may be available.
063 This OT code only billed on partial hospitalization claims.
064 AT service not payable outside the partial hospitalization program.
065 Revenue code not recognized by Medicare.
066 Code requires manual pricing.
067 Service provided prior to FDA approval.
068 Service provided prior to date of National Coverage Determination (NCD) approval.
069 Service provided outside approval period.
070 CA modifier requires patient status code 20.
071 Claim lacks required device code.
072 Service not billable to the Fiscal Intermediary/Medicare Administrative Contractor.
073 Incorrect billing of blood and blood products.
074 Units greater than one for bilateral procedure billed with modifier 50.
075 Incorrect billing of modifier FB or FC.
076 Trauma response critical care code without revenue code 068x and CPT 99291.
077 Claim lacks allowed procedure code.
078 Claim lacks required radiolabeled product.
079 Incorrect billing of revenue code with HCPCS code

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080	Mental health code not approved for partial hospitalization.
081	Mental health service not payable outside the partial hospitalization program.
083	Service provided on or after effective date of NCD non-coverage.
084	Claim lacks required primary code.
085	Claim lacks required device code or required procedure code.
086	Manifestation code not allowed as principal diagnosis.
087	Skin substitute application procedure without appropriate skin substitute product code.
092	Device-dependent procedure reported without device code.
093	Corneal tissue processing reported without cornea transplant procedure.
094	Biosimilar HCPCS reported without biosimilar modifier.
095	Partial hospitalization claim span is equal to or more than 4 days with insufficient number of hours of service.
096	Partial hospitalization interim claim from and through dates must span more than 4 days.
097	Partial hospitalization services are required to be billed weekly.
098	Claim with pass-through device lacks required procedure.
099	Claim with pass-through or non-pass-through drug or biological lacks OPPS payable procedure.
APC	Claim processed using Ambulatory Payment Classification methodology. Charges may be subject to reprocessing should facility correct billing.
AP1	Invoice required per APC facility contract.
AP2	Drug item processed per APC facility contract.
AP3	Lab and/or mammography service(s) processed per APC facility contract.
AP4	Per Medicare's Medically Unlikely Edits Policy, the units of service billed for this procedure exceed the allowed units.
AP5	Item or service expected to be denied as not reasonable and necessary.
AP6	Multiple medical visits (based on units and/or lines) are present on the same day with the same revenue code, without condition code G0 to indicate that the visits were distinct and independent of each other.
AP7	This diagnostic procedure code billed by a facility requires a TC modifier. TC Modifier was added to this procedure.
AP8	This procedure code should be reviewed for a potential multiple procedure reduction.
AP9	Review historical procedure for a potential multiple procedure reduction with this procedure code.
A10	This service is not appropriate for medicare patients in an ambulatory surgery center setting.
A11	Service does not meet the guidelines for TOB 14x.
A12	The taxonomy of the provider does not match the bill type.
A13	This is a duplicate line item.
A14	Line should be excluded from charges.
A15	Supplementary or additional code not allowed as principal diagnosis.
A16	Modifiers PO/PN not allowed on the same line
A17	Modifier reported prior to FDA approval date
A18	Service not eligible for all-inclusive rate
A19	Claim reported with pass-through device prior to FDA approval for the procedure
A20	Add-on code reported without required primary procedure code
A21	Add-on code reported without required contractor-defined primary procedure code
A22	Add-on code reported without required primary procedure or required contractor-defined primary procedure code
A23	Code first diagnosis present without mental health diagnosis as the first secondary diagnosis
A24	Service provided prior to initial marketing data
A25	Service cost is duplicative; included in cost of associated biological
A26	Information only service(s)
A27	Item or service not allowed with modifier CS
A28	COVID-19 lab add-on code reported without required primary procedure
A29	Opioid treatment program service not payable outside the opioid treatment program
ANA	Line(s) on this claim are allowing more than billed as a result of special contract payment methodology (APC). APC assigns allowed amounts based on services incurred and will not allow more than billed on an entire claim. Please refer to total line calculation of claim.
C1	The amount billed to provider is recognized as Reasonable and Allowed and is in accordance with CMS pricing that typically limits the maximum amount payable to 140% of the Medicare Allowable.
C2	Negotiated Agreement with CTI Health Solutions. Please call 541-618-6533 or email admin@aahealthsolutions.com for questions regarding this payment.
C3	Please call CTI Health Solutions at 541-618-6533 or email admin@aahealthsolutions.com if a balance due bill from your provider is received.
C4	Important information: Reasonable and Allowed. The amount exceeds the Reasonable and Allowed Amount that typically limits the maximum amount payable to 140% of the Medicare Allowable. Health care providers are reimbursed according to the governing Plan Document and generally does not exceed the Reasonable and Allowed amount with the exception of deductibles, copays and coinsurance. According to the terms of the Plan Document, an Assignment of Benefits (AOB) is only valid when a provider accepts the Reasonable and Allowed Amount as payment in full for services performed. Payment in full relinquishes the providers right to balance bill the Plan Participant, represents accord and satisfaction, and will take priority over any previous terms. The Plan Participant has the right to appeal an adverse benefit determination (in whole or in part). The initial appeal must be submitted with (180) days following the receipt of the denial. Notice of an appeal decision will be provided within 30 days of receipt of the request. For questions regarding this claim and/or the denied charges please feel free to

	email customer-service@dakotacare.com or call (800)935-0404 or mail to: Ayin Administrative Health Solutions 5300 S Broadband Ln Sioux Falls, SD 57108-2221. Notice: This is a conditional payment for a compromised settlement and depositing the enclosed check (ACH) expressly acknowledges that a full and final payment has been made for the delineated billed charges and this payment constitutes a full accord and satisfaction of the said charges such that the tendered amount is full satisfaction. Should you appeal, if there is an enclosed check, please void and return to sender.
C5	Important Information: The Plan Participant has the right to appeal an adverse benefit determination (in whole or in part). The initial appeal must be submitted within (180) days following the receipt of the denial. Notice of an appeal decision will be provided within 30 days of receipt of the request. For questions regarding this claim and/or the denied charges please feel free to email customer-service@dakotacare.com or call (800) 935- 0404 or mail to: Ayin Administrative Health Solutions 5300 S Broadband Ln Sioux Falls, SD 57108-2221. Notice: This is a conditional payment for a compromised settlement and depositing the enclosed check (ACH) expressly acknowledges that a full and final payment has been made for the delineated billed charges and this payment constitutes a full accord and satisfaction of the said charges such that the tendered amount is full satisfaction. Should you appeal, if there is an enclosed check, please void and return to sender.
CTI	Public Health Emergency Telehealth, 100%.
CRS	COVID-19 Related Services, 100%.
H00	Claim submitted to HST.
H01	The amount billed was considered for Reasonable and Allowed reimbursement, based on CMS pricing that generally limits the maximum amount payable to 140% of the Medicare allowable.
H02	Negotiated Agreement with HST. For questions regarding this payment, call 800-935-0404.
H10	28-Code not recognized by Medicare; alt code for same service available.
H11	62-Code not recognized by OPPS resubmit and refer to CMS OPPS.
H12	A1-Invalid or Missing HIPPS Code.
H13	50-Non-covered under Medicare outpatient benefit, on statutory exclusion.
H14	A2-Invalid bill type for facility.