

Date of Change	Page	Local Value	HIPAA Value	Description of Change
10/18/07	All	N/A	N/A	Changed all Department of Health Services (CDHS) references to Department of Health Care Services (DHCS).
02/14/06	37	493	14	Modification to Medi-Cal Status Code description.
08/12/04	39	521	101	Correction to HIPAA value and description.

276/277 Transaction Code Correlation Table

Providers using the 276/277 Claim Status Request and Response transaction may see new code numbers appear in *the Health Care Claim Status Category Code* field and *Health Care Claim Status Code* field, effective July 19, 2004. These are new HIPAA-mandated national codes that replace Medi-Cal local codes.

The following correlation table shows the definition and relationship between old and new health care claim status category codes and health care claim status codes.

Claim Category Code Description Modification:

Category Code	Description (Before Change)	Description (After Change)
F0	Your claim will appear on a subsequent warrant.	Finalized. The claim/encounter has completed the adjudication cycle and no more action will be taken.
F1	Your claim has been paid.	Finalized/Payment. The claim/line has been paid.
F2	Your claim has been denied.	Finalized/Denial. The claim/line has been denied.
F2	This claim is a tape-to-tape zero suppress crossover claim. This claim was crossed over from a Medicare Carrier. The Medi-Cal allowable payment has been reached or exceeded by Medicare, therefore no Medi-Cal payment is allowed. This claim will not appear on your RA or EOB.	Finalized/Denial. The claim/line has been denied.
F3	A system offset has been generated as a result of an approved adjustment for a negative amount.	Finalized/Revised. Adjudication information has been changed.
PO	Your claim is pending adjudication.	Pending: Adjudication/Details. This is a generic message about a pended claim. A pended claim is one for which no remittance advice has been issued, or only part of the claim has been paid.
P1	Your claim is in process.	Pending/In Process. The claim or encounter is in the adjudication system.
R0	Your claim has been RTDed.	Requests for additional Information/General Requests that don't fall into other R-type categories.

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Claim Status Code and Description Modification:

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
1	The recipient is not eligible on the date of service billed.	90	Entity not eligible for medical benefits for submitted dates of service.
2	The recipient is not eligible for benefits under the Medi-Cal program.	109	Entity not eligible.
3	The proof of eligibility label given is not valid for the dates of service reported.	21	Missing or invalid information.
4	The recipient information billed on the claim does not correspond to the <i>Treatment Authorization Request</i> .	48	Referral/Authorization.
5	The service billed requires an approved <i>Treatment Authorization Request</i> .	48	Referral/Authorization.
6	The date of service reported on the claim does not correspond to the approved <i>Treatment Authorization Request</i> .	48	Referral/Authorization.
7	The number of refills billed on the claim exceeds the number approved on the <i>Treatment Authorization Request</i> .	48	Referral/Authorization.
8	The provider of service is not eligible for the type of services billed.	250	Type of service.
9	This service or NDC (National Drug Code) is not a covered benefit of the program.	218	NDC number.
10	This service is a duplicate of a previously paid claim.	54	Duplicate of a previously processed claim/line.
11	The attending/referring/prescribing provider is not eligible to prescribe the service billed.	441	Entity professional qualification for service(s).
12	Medi-Cal benefits cannot be paid without proof of payment or denial from Medicare.	286	Other payer's Explanation of Benefits/payment information.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
13	Medi-Cal benefits cannot be paid without proof of payment or denial from CHAMPUS.	286	Other payer's Explanation of Benefits/payment information.
14	Medi-Cal benefits cannot be paid without proof of payment or denial from Ross-Loos (CIGNA).	286	Other payer's Explanation of Benefits/payment information.
15	Medi-Cal benefits cannot be paid without proof of payment or denial from Kaiser.	286	Other payer's Explanation of Benefits/payment information.
16	The drug or medical supply billed is not listed on the Medi-Cal formulary for the date of service.	9	No payment will be made for this claim.
17	The quantity or number dispensed is not in accordance with the current Medi-Cal formulary.	222	Drug dispensing units and average wholesale price (AWP).
18	An approved <i>Treatment Authorization Request</i> is required for the drug combination billed.	84	Service not authorized.
19	The Code 1 restrictions for this drug were not met.	216	Drug information.
20	This claim was received after the six-months following the month of service billing limitation.	187	Date(s) of service.
21	This claim was received after the one-year maximum billing limitation.	187	Date(s) of service.
22	This service is the patient's liability (Share of Cost).	98	Charges applied to deductible.
23	The strength or principal labeler billed is not a benefit of the Medi-Cal program.	217	Drug name, strength and dosage form.
24	This patient is not eligible for the drug or medical supply billed.	109	Entity not eligible.
25	Quantity billed exceeds the maximum allowed amount or usual practice. Please check to see if quantity was billed using correct units.	476	Missing or invalid units of service.
26	Date of service was prior to a fiscal year for which GHPP funds are available.	90	Entity not eligible for medical benefits for submitted dates of service.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
27	Services denied by Medicare are not payable by Medi-Cal.	9	No payment will be made for this claim.
28	This drug is billable only for multiple patients in an ICF or SNF.	218	NDC number.
29	This procedure is allowable only once per date of service.	259	Frequency of service.
30	Date of death prior to date of service.	159	Entity's date of death.
31	The rendering provider was not eligible for the services billed on the date of service.	109	Entity not eligible.
32	The prescribing provider was not eligible for this category of service on the date of service billed.	109	Entity not eligible.
33	The recipient is not eligible for the service billed.	109	Entity not eligible.
34	Services provided for this diagnosis are not payable for a GHPP claim.	488	Diagnosis code(s) for the services rendered.
35	This claim does not correspond to the approved submitted <i>Treatment Authorization Request</i> .	48	Referral/Authorization.
36	RTD was either not returned or was returned uncorrected; therefore your claim is formally denied.	95	Requested additional information not received.
37	This service is not billable to Medi-Cal because the recipient is enrolled in a Health Care Plan.	105	Claim/line is capitated.
38	This service is not a Medi-Cal benefit without an explanation that usage is for specified conditions.	287	Medical necessity for service.
39	Claims with a "ZZ" manufacturer cannot be processed without a catalog or price reference book page, listing the item billed.	294	Supporting documentation.
40	This service is not payable without a catalog or price reference book page listing the item billed.	294	Supporting documentation.
41	Medi-Cal benefits cannot be paid without proof of payment or denial from other coverage Carrier.	286	Other payer's Explanation of Benefits/payment information.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
42	Date of service missing or invalid.	187	Date(s) of service.
43	Patient status code is not appropriate for accommodation code listed.	21	Missing or invalid information.
44	Accommodation code is not appropriate for patient status code listed.	21	Missing or invalid information.
45	Service period is in excess of allowed days for patient status.	187	Date(s) of service.
46	POE label does not match recipient data on claim form.	21	Missing or invalid information.
47	<i>Treatment Authorization Request</i> invalid for services and/or period billed.	48	Referral/Authorization.
48	Patient discharged within 24 hours of Leave of Absence return.	234	Patient discharge status.
49	Provider billing error; claim line invalid.	21	Missing or invalid information.
50	Denied as a result of internal processing error. Claim is now being reprocessed.	20	Accepted for processing.
51	Signature is missing or is not an original.	466	Entity's original signature.
52	Resubmission turnaround document returned unsigned or without requested information.	95	Requested additional information not received.
53	Unable to process claim due to illegibility or incorrect format.	481	Claim/Submission format is invalid.
54	Our records do not show that this manufacturer makes the products billed.	21	Missing or invalid information.
55	The primary/secondary diagnosis code has no match on the diagnosis file. Primary not Incontinence, secondary Incontinence.	488	Diagnosis code(s) for the services rendered.
56	Billing error: Refer to use of modifier ZM, ZN, 97, 98 or 99 for correct billing of supplies.	453	Procedure code modifier(s) for service(s) rendered.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
57	Billing error: Refer to provider manual for proper billing code.	454	Procedure code for services rendered.
58	The procedure code is inconsistent with the primary diagnosis code.	454	Procedure code for services rendered.
59	The combination of procedure code and type has no match on the procedure file.	454	Procedure code for services rendered.
60	Invalid record.	21	Missing or invalid information.
61	The procedure code and type are not a covered benefit on the date of service.	454	Procedure code for services rendered.
62	The place of service is not acceptable for this procedure, drug, NDC or medical supply.	249	Place of service.
63	The procedure is not consistent with the recipient's age.	475	Procedure code not valid for patient age.
64	The procedure is not consistent with the recipient's sex.	474	Procedure code and patient gender mismatch.
65	The provider type is not allowed to perform this procedure.	109	Entity not eligible.
66	The reimbursement information on claim is not equal to Medicare Coinsurance and deductible amounts indicated on the invoice.	285	Vouchers/Explanation of Benefits (EOB).
67	The primary/secondary surgical procedure code has no match on the procedure file.	454	Procedure code for services rendered.
68	Billing error: Refer to CPT-4 or provider manual for proper procedure code.	454	Procedure code for services rendered.
69	This is a duplicate of a previous adjustment.	54	Duplicate of a previously processed claim/line.
70	Denied by vision care claims review. Not reconsidered per provider.	9	No payment will be made for this claim.
71	The maximum allowed for this service/procedure has been paid.	67	Payment made in full.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
72	This service is included in another procedure code billed on the same date of service.	454	Procedure code for services rendered.
73	Billing error: Procedure code Z7610 or 99070 is inappropriate for billing this type of item.	454	Procedure code for services rendered.
74	This service is included in the surgical fee.	454	Procedure code for services rendered.
75	The necessary documentation was not received.	294	Supporting documentation.
76	The submitted documentation was not adequate.	294	Supporting documentation.
77	This transportation must be ordered by a physician for reasons of medical necessity.	287	Medical necessity for service.
78	Rural Health Clinic dental services for CMSP beneficiaries aren't processed by Fiscal Intermediary. Send claim to CMSP, 714 P Street, Room 523, Sacramento, California, 95814.	116	Claim submitted to incorrect payer.
79	Services billed exceed the occurrences remaining on the approved <i>Treatment Authorization Request</i> .	84	Service not authorized.
80	Procedure code invalid for admission type.	454	Procedure code for services rendered.
81	The specific item billed is not a benefit of the Medi-Cal program.	9	No payment will be made for this claim.
82	Services exceed maximum allowed by Medi-Cal policy.	259	Frequency of service.
83	Provider not Medicare certified for lab procedure on date of service. Please contact provider enrollment section.	142	Entity's license/certification number.
84	Accommodation cost center inappropriate for age of recipient.	475	Procedure code not valid for patient age.
85	Ancillary code has no match on procedure file.	21	Missing or invalid information.
86	OBRA/IRCA, 100 percent, 133 percent, 185 percent and 200 percent recipients are not eligible for LTC or vision care services.	109	Entity not eligible.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
87	This procedure has been performed previously for this recipient, payable only once in a lifetime.	259	Frequency of service.
88	Secondary diagnosis code is invalid for the age of the recipient.	255	Diagnosis code.
89	Secondary diagnosis code is invalid for the sex of the recipient.	255	Diagnosis code.
90	The combination of service code and modifier is not valid.	453	Procedure code modifier(s) for service(s) rendered.
91	Our records do not show documentation for the modifier billed.	294	Supporting documentation.
92	Short Doyle mental health services are not reimbursable by Medi-Cal; submit to the State's program office.	116	Claim submitted to incorrect payer.
93	Non-emergency services are not payable for limited service OBRA/IRCA recipients.	109	Entity not eligible.
94	Rendering provider not eligible for group type. Resubmit using individual provider number or under appropriate group type.	21	Missing or invalid information.
95	This service is not payable due to a procedure or procedure and modifier previously reimbursed.	54	Duplicate of a previously processed claim/line.
96	This service requires an original Medi-label, Medi-reservation, or approved TAR.	48	Referral/Authorization.
97	Billed services are not payable due to a no-fee billing agreement.	9	No payment will be made for this claim.
98	Hospital contract exception. Requires provider certification.	142	Entity's license/certification number.
99	Well-child services provided by CHDP providers must be billed to CHDP.	116	Claim submitted to incorrect payer.
100	Certification of emergency Invalid.	299	Emergency room notes/report.
101	CCS/GHPP authorization incomplete. Contact CCS/GHPP regional office.	48	Referral/Authorization.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
102	This service requires an original Medi-label or Medi-reservation.	48	Referral/Authorization.
103	Certification of previous sterility invalid.	21	Missing or invalid information.
104	Emergency certification is required. Not present on claim.	21	Missing or invalid information.
105	This service requires a valid consent for sterilization form.	21	Missing or invalid information.
106	This procedure/accommodation is payable only when billed with other procedure/accommodation codes.	454	Procedure code for services rendered.
107	Pre-operative visit included in reimbursement for surgery.	9	No payment will be made for this claim.
108	This consultation billed by a podiatrist requires a report.	297	Medical notes/report.
109	Sales tax is not payable for some DME supplies or eye appliances.	67	Payment made in full.
110	This DME without a TAR requires an invoice.	110	Claim requires pricing information.
111	This provider type is ineligible for the modifier billed.	441	Entity professional qualification for service(s)
112	These related DME require a TAR.	84	Service not authorized.
113	This procedure is payable only once in 90 days.	259	Frequency of service.
114	Documentation does not justify collection and handling fee.	294	Supporting documentation.
115	Sterilization consent form incomplete. A letter has been sent which indicates needed corrections.	21	Missing or invalid information.
116	This procedure is payable only once per month.	259	Frequency of service.
117	This procedure is payable only twice per month.	259	Frequency of service.
118	This procedure is payable only eight times in 120 days.	259	Frequency of service.
119	This procedure is payable only once in 6 months when justified.	259	Frequency of service.
120	This procedure is payable only once per year.	259	Frequency of service.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
121	Duplicate cost center or service codes have been billed on the same claim.	54	Duplicate of a previously processed claim/line.
122	This procedure is not payable with the qualifier code billed.	21	Missing or invalid information.
123	This procedure is payable only once every 24 months.	259	Frequency of service.
124	This is a treatment period procedure that requires from through billing.	481	Claim/submission format is invalid.
125	Low vision aid not billed, examination not payable.	9	No payment will be made for this claim.
126	This rendering provider is not licensed to provide services with the billing provider on date of service.	441	Entity professional qualification for service(s).
127	This procedure is not payable without a split billing agreement.	454	Procedure code for services rendered.
128	This procedure is payable only once in 60 days.	259	Frequency of service.
129	Payment reduced to medical/surgical contract rate. Primary surgical diagnosis code does not justify ICU contract rate.	254	Primary diagnosis code.
130	Payment/denial notice does not indicate recipient name and/or date of service.	171	Other insurance coverage information (health, liability, auto, etc.).
131	This consultation is not payable due to exchange transfusion previously billed by same provider.	9	No payment will be made for this claim.
132	Incorrect Medicare billing/payment. Please reconcile with Medicare prior to billing Medi-Cal.	21	Missing or invalid information.
133	Failure to provide adequate justification for procedure or appliance billed.	287	Medical necessity for service.
134	Proof of part B payment/denial required; Enter part B payment in other coverage box.	286	Other payer's Explanation of Benefits/payment information.
135	Medicare documentation not acceptable; no SSN or incorrect SSN given to SSA/Medicare Fiscal Intermediary.	21	Missing or invalid information.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
136	Medicare documentation not acceptable; recipient statements, alien cards not acceptable.	294	Supporting documentation.
137	Billing cannot precede date of service or date of appliance delivery.	187	Date(s) of service.
138	Modifier invalid for the claim type.	453	Procedure code modifier(s) for service(s) rendered.
139	Procedure/service code is invalid for claim type on date of service.	454	Procedure code for services rendered.
140	This is not a valid code for billing Medi-Cal services; for Medicare correlation only.	454	Procedure code for services rendered.
141	Lenses and component not validated due to absent or incomplete visual acuities.	21	Missing or invalid information.
142	Valid drug use review response required	21	Missing or invalid information.
143	Comparable accommodation codes, bills on the same date of service or overlapping dates of service.	454	Procedure code for services rendered.
144	Acute level billed not payable for authorized administrative days.	9	No payment will be made for this claim.
145	This procedure is not payable on this date of service.	9	No payment will be made for this claim.
146	CCN or original claim required. Please resubmit.	21	Missing or invalid information.
147	Trifocal lenses covered only when previously worn.	21	Missing or invalid information.
148	Labor for installation/repair of a denied item is not payable.	9	No payment will be made for this claim.
149	Incorrect original CCN submitted on CIF.	21	Missing or invalid information.
150	Medicare documentation not acceptable; documentation not dated, or not valid for date of service billed.	294	Supporting documentation.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
151	Medicare documentation not acceptable; incomplete or inappropriate information given to SSA/Medicare Fiscal Intermediary. Resubmit to Medicare F.I.	294	Supporting documentation.
152	Medicare documentation not acceptable; illegible or no indication this information came from SSA/Medicare Fiscal Intermediary.	294	Supporting documentation.
153	Medicare denial indicates this service was reimbursed through another provider or hospital. Please seek reimbursement from that provider or hospital.	116	Claim submitted to incorrect payer.
154	Non-emergency services are not payable for limited service 185 percent recipients.	9	No payment will be made for this claim.
155	The prescribing/referring provider number is missing or invalid.	21	Missing or invalid information.
156	This service or procedure ineligible for from/through billing by this provider type for this place of service.	481	Claim/submission format is invalid.
157	Claims for recipients in fabricating optical laboratory counties are limited to frames and dispensing fees only. Lenses are billed by the fabricating laboratory.	9	No payment will be made for this claim.
158	"From" date of service not the same month/year as "to" date of service. Split bill claim for the individual months.	481	Claim/Submission format is invalid.
159	Medicare coinsurance maximum exceeded. Rebill on hard copy, attaching Medicare RA.	294	Supporting documentation.
160	Medicare part A payment, denial or proof of non-eligibility required.	294	Supporting documentation.
161	This procedure/service cannot "from-through" billed beyond the November 1, 1987 CPT conversion date.	481	Claim/Submission format is invalid.
162	Documentation does not substantiate procedure billed.	294	Supporting documentation.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
163	Provider must submit documentation showing that OHC carrier did not respond within 90 days.	294	Supporting documentation.
164	Admission denied by medical review. Medical necessity not established.	287	Medical necessity for service.
165	Explanation of medical necessity for quantity used required. Please see EOB/RA section of provider manual for details.	287	Medical necessity for service.
166	Hospice continuous home care must be billed for more than eight hours, and cannot be block billed.	481	Claim/Submission format is invalid.
167	Hospice codes Z7110 must be billed with place of service 4. Hospice codes Z7112 must be billed with place of service C.	249	Place of service.
168	More than one type of hospice care not payable for any recipient on the same or overlapping dates of service.	187	Date(s) of service.
169	This service is not payable when billed with this diagnosis.	488	Diagnosis code(s) for the services rendered.
170	Claim is not payable for recipients aged 22 through 64 in IMD facilities.	109	Entity not eligible.
171	Medi-Cal only pays Medicare coinsurance and deductible for qualified Medicare recipients (aid code 80), as allowed.	109	Entity not eligible.
172	Acute or incorrect level of care billed for authorized sub acute ventilator-dependent level of care.	21	Missing or invalid information.
173	Sub acute care not payable when billed with any other accommodation code. Correct billing and resubmit.	455	Revenue code for services rendered.
174	Acute or incorrect level of care billed for authorized sub acute-ventilator-dependent level of care.	21	Missing or invalid information.
175	Karnofsky scale rating invalid for AIDS waiver.	21	Missing or invalid information.
176	Postpartum visit limited to one in six months.	259	Frequency of service.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
177	The procedure billed represents a panel or a related panel component which has been paid in history.	9	No payment will be made for this claim.
178	Global OB billing not payable when individually billed antepartum visits paid within global billing period.	9	No payment will be made for this claim.
179	Antepartum visits not payable due to conflicting history claim for global OB delivery.	9	No payment will be made for this claim.
180	This service requires a TAR for the billing provider type on the date of service billed.	84	Service not authorized.
181	The service requires a TAR for the place of service on the date of service billed.	84	Service not authorized.
182	The service requires a TAR for the billing provider type and place of service on the date of service billed.	84	Service not authorized.
183	The service requires a Medi-label or a Medi-reservation for the billing provider type on the date of service billed.	48	Referral/Authorization.
184	This procedure has been deemed "not medically necessary" by the medical review and is being denied. Justification required.	287	Medical necessity for service.
185	Denied by Special Claims Review. Documentation does not support procedure billed. No reduced level of service identified for procedure. Resubmit with correct code or required documentation.	294	Supporting documentation.
186	The service requires a Medi-label or Medi-reservation for the place of service on the date of service billed.	48	Referral/Authorization.
187	The service requires a Medi-label or Medi-reservation for billing provider type and place of service on date of service billed.	48	Referral/Authorization.
188	This is a "By Report" procedure, no report attached.	297	Medical notes/report.
189	Medications or supplies not listed.	21	Missing or invalid information.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
190	Excess services denied by audit.	46	Internal review/Audit.
191	Split billing modifier billed inappropriately.	453	Procedure code modifier(s) for service(s) rendered.
192	Request for additional information not received by Medical review, this claim is being denied.	95	Requested additional information not received.
193	This procedure has been combined and processed under the appropriate lab panel code.	12	One or more originally submitted procedure codes have been combined.
194	The recipient is eligible only for services related to renal disease.	109	Entity not eligible.
195	This claim was reviewed by office of AIDS and deemed not payable. Contact office of AIDS for further information.	9	No payment will be made for this claim.
196	This procedure requires a modifier. Modifier is not present.	453	Procedure code modifier(s) for service(s) rendered.
197	Documentation submitted with claim does not justify the use of anesthesia.	294	Supporting documentation.
198	Billing error: Refer to injection code drug list in the provider manual.	454	Procedure code for services rendered.
199	Documentation submitted with claim does not justify 100 percent reimbursement.	294	Supporting documentation.
200	Documentation does not establish the medical necessity for an assistant surgeon.	287	Medical necessity for service.
201	Absorptive lenses may be provided only with a diagnosis of aphakia or pseudoaphakia, or to replace prior absorptive lenses.	488	Diagnosis code(s) for the services rendered.
202	The primary ICD-9 diagnosis code is invalid for the age of the recipient.	254	Primary diagnosis code.
203	The primary ICD-9 diagnosis code is invalid for the sex of the recipient.	86	Diagnosis and patient gender mismatch.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
204	This procedure/service is not eligible for block billing (from-thru).	481	Claim/submission format is invalid.
205	Procedure was found in history with a conflicting modifier for the same date of service.	453	Procedure code modifier(s) for service(s) rendered.
206	With the information received to date by Medical Review, this does not qualify as an emergency admission.	294	Supporting documentation.
207	This procedure is considered to be included in the charge for total obstetrical care.	12	One or more originally submitted procedure codes have been combined.
208	Inappropriate injection code billed.	454	Procedure code for services rendered.
209	Documentation does not justify the frequency of visits billed.	294	Supporting documentation.
210	This level of care is not justified by Medical Review.	294	Supporting documentation.
211	This procedure is payable only once per month (30 days) for the diagnosis provided.	259	Frequency of service.
212	This procedure is not payable when billed with an office visit.	454	Procedure code for services rendered.
213	The procedure code billed is invalid for this provider type.	454	Procedure code for services rendered.
214	Documentation does not indicate that the physical therapy was performed by the M.D.	294	Supporting documentation.
215	Documentation does not warrant an office visit on the same day as the physical therapy.	294	Supporting documentation.
216	The office visit is included in the physical therapy procedure on the same day of service.	12	One or more originally submitted procedure codes have been combined.
217	This procedure is included in the radiation therapy treatment.	12	One or more originally submitted procedure codes have been combined.
218	This procedure falls within the follow-up period of radiation therapy and is not payable.	12	One or more originally submitted procedure codes have been combined.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
219	This procedure falls within the follow-up period of surgery and is not payable.	12	One or more originally submitted procedure codes have been combined.
220	A hysterectomy is not payable when performed only for the purpose of rendering an individual permanently sterile.	9	No payment will be made for this claim.
221	This incidental procedure is considered to be included in the primary surgical procedure.	9	No payment will be made for this claim.
222	The billed quantity for the drug claim is not within the TAR authorized range specified by the TAR quantity and /or percent variance.	48	Referral/Authorization.
223	The sterilization procedure was not performed in accordance with the required time period.	187	Date(s) of service.
224	This code requires an itemization of the services or supplies billed (e.g., lab tests, unlisted supplies/ambulance supplies)	280	Itemized claim by provider.
225	This is an incorrect procedure code and/or modifier code for this service. Please resubmit.	453	Procedure code modifier(s) for service(s) rendered.
226	The State has determined that this procedure or service is not a Medi-Cal benefit.	454	Procedure code for services rendered.
227	Administrative cap per contract has been exceeded.	483	Maximum coverage amount met or exceeded for benefit period.
228	Recipient was not an active AIDS client on the date of service. Contact Field Services.	88	Entity not eligible for benefits for submitted dates of service.
229	Contractor provider number on claim does not match client file.	21	Missing or invalid information.
230	AIDS waiver claims require an AIDS or ARC diagnosis for date of service. Contact Field Services.	255	Diagnosis code.
231	Recipient not eligible for Medi-Cal without complete denial of coverage letter from AETNA.	286	Other payer's Explanation of Benefits/payment information.
232	Medi-Cal frequency for service was exceeded. Further	287	Medical necessity for service.

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Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	justification is required.		
233	Medi-Cal frequency for service was exceeded. Justification is insufficient.	287	Medical necessity for service.
234	The yearly capitation for this recipient has been exceeded for HCBS Nursing Facility Level B waiver services (Z6716–Z6726).	483	Maximum coverage amount met or exceeded for benefit period.
235	Recipient on restricted services. Medical Review determined the Emergency Room statement is not adequate. Additional justification or a TAR is required.	294	Supporting documentation.
236	Laboratory procedure code requires proficiency testing. Please contact Provider Enrollment Section.	441	Entity professional qualification for service(s).
237	The TAR control number suffix submitted on the claim does not match the suffix found on the TAR.	48	Referral/Authorization.
238	Denied by Special Claims Review, required documentation was not received. Refer to SCR provider letter for documentation requirements. Resubmit with required documentation.	294	Supporting documentation.
239	Denied by Special Claims Review, submitted documentation inadequate. Refer to SCR provider Letter for documentation requirements. Resubmit with required documentation.	294	Supporting documentation.
240	Denied by Special Claims Review, document does not support the service billed. Resubmit with documentation which includes the indication for this service.	294	Supporting documentation.
241	Denied by Special Claims Review, prior authorization was not received or was not valid for date of service billed. Resubmit with proof of prior authorization valid for date of service.	48	Referral/Authorization.
242	Prior authorization required for this service is not present or is invalid. Contact DHCS to request proper authorization.	84	Service not authorized.
243	The TAR Control Number submitted on the claim is not found	48	Referral/Authorization.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	on the TAR master file.		
244	The State has determined that this hospitalization is not medically justified.	287	Medical necessity for service.
245	Medi-Cal is not obligated to pay for HMO/PHP, HF, Kaiser, CHAMPUS or Medicare HMO covered services when the recipient chooses not to go to a plan provider.	105	Claim/line is capitated.
246	General or admit TAR not found on the TAR master file for this extension TAR.	48	Referral/Authorization.
247	Procedure/modifier, drug/NDC code billed is covered in the sub acute per diem rate and is not separately payable.	12	One or more originally submitted procedure codes have been combined.
248	Rural Health Clinics must bill per-visit codes only. (Visit codes 01-05 for non-CMSP recipients)	454	Procedure code for services rendered.
249	Services provided to a CMSP aid code 50 Out of County Care recipient are not payable to providers outside a CMSP county.	107	Processed according to contract/plan provisions.
250	Quantity exceeds allowed for per-visit codes, or a claim with the same date of service and the same per-visit code was found in history. Medical justification required.	287	Medical necessity for service.
251	Recipient is eligible for Medicare, EOMB required.	285	Vouchers/Explanation of Benefits (EOB).
252	The recipient information does not match. Verify claims input.	109	Entity not eligible.
253	Provider not certified for the laboratory procedure billed or for specialty on this date of service.	142	Entity's license/certification number.
254	Inpatient crossover claims are not reimbursable under the HSM, HST or HSD provider ID.	21	Missing or invalid information.
255	Rendering provider is not on the Provider Master File or is not a clinical lab.	142	Entity's license/certification number.
256	Denied by Vision Care Claims Review – prescription/visual	21	Missing or invalid information.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	acuity data is required.		
257	Denied by Vision Care Claims Review – eye exam within 24 months requires date of prior exam/justification.	21	Missing or invalid information.
258	Denied by Vision Care Claims Review – justification missing or is not adequate.	287	Medical necessity for service.
259	Denied by Vision Care Claims Review – is not a Medi-Cal benefit.	9	No payment will be made for this claim.
260	Denied by Vision Care Claims Review – refractionist’s signature is required.	466	Entities original signature.
261	Denied by Vision Care Claims Review – current/prior prescription is not present/adequate.	21	Missing or invalid information.
262	Denied by Vision Care Claims Review – prior authorization required.	84	Service not authorized.
263	Computer media supporting remarks aren't acceptable for this procedure due to the requirement for invoice, current catalog page, or other hard copy form (Medicare EOMB) or signature.	294	Supporting documentation.
264	Denied by Vision Care Claims Review – visual acuity data is not present/adequate.	21	Missing or invalid information.
265	Denied by Vision Care Claims Review – diagnosis does not justify service billed.	488	Diagnosis code(s) for the services rendered.
266	Denied by Vision Care Claims Review – resubmitted claim requires justification/documentation.	294	Supporting documentation.
267	Provider ID on claim must match provider ID on TAR when billing for HCBS services.	124	Entity's name, address, phone and ID number.
268	The monthly capitation for this recipient has been exceeded for HCBS Model Waiver Services (Z6730 – 6740), or AIDS Waiver	483	Maximum coverage amount met or exceeded for benefit period.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	yearly services (Z5000 – Z5016 and Z5020 – Z5022).		
269	Date of service appears to be inconsistent with other claim elements.	187	Date(s) of service.
270	Common day/per diem OB care accommodations cannot be billed within same period.	454	Procedure code for services rendered.
271	Verification of need must be signed by prescribing physician and dated within 6 months of date of service. Refer to Special Claims Review letter for documentation requirements.	294	Supporting documentation.
272	OB and nursery accommodation/revenue codes are not payable when billed within the same billing period. Resubmit using common day accommodation code 3998 (LA-Waiver code 98).	454	Procedure code for services rendered.
273	The recipient is a member of a county health initiative.	105	Claim/line is capitated.
274	Claims for these services are not processed by the Medi-Cal Fiscal Intermediary.	105	Claim/line is capitated.
275	This is a duplicate TAR Control Number.	252	Authorization/Certification number.
276	Repair/maintenance of a DME is limited to \$50 a month without a TAR.	48	Referral/Authorization.
277	Service frequency exceeds usual, further justification required.	287	Medical necessity for service.
278	Net amount billed exceeds 20 percent of Medicare allowed plus deductible. Rebill on hard copy, attaching Medicare RA.	285	Vouchers/Explanation of Benefits (EOB).
279	HCP/Mental Health Plan provider authorization invalid.	48	Referral/Authorization.
280	Required authorization for services to HCP/Mental Health Plan recipient was not found. Contact the HCP recipient contractor/ CMHO for clarification of requirements.	48	Referral/Authorization.
281	At-risk/capitated service on date of service billed for PCCM recipient payable by PCCM, not payable by Medi-Cal F.I.	116	Claim submitted to incorrect payer.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
282	Health Care Plan is not on file.	479	Other carrier payer ID is missing or invalid.
283	Administrative days are not payable under this contract provider ID number. Resubmit, if appropriate, under non-contract provider ID number.	124	Entity's name, address, phone and ID number.
284	Aid code 55 recipients are not eligible for vision care services.	109	Entity not eligible.
285	Reimbursement for antepartum office visits is limited to eight in nine months.	259	Frequency of service.
286	The "from" date of service must be at least 100 days from the "through" date of service.	187	Date(s) of service.
287	Contracted hospitals billing for OB care must use CHFC accommodation/revenue code 3998, UB-92 accommodation code 096 LA waiver code 98. Correct and resubmit claim.	454	Procedure code for services rendered.
288	The six month billing limit exception indicator is invalid for CMC. Resubmit on hard copy with substantiating documentation.	294	Supporting documentation.
289	Recipient is on Lock-In/Drug restriction – TAR Control Number not found or no emergency statement attached.	84	Service not authorized.
290	Recipient on Lock-In/Restriction. Prior authorization required.	84	Service not authorized.
291	Ordering/Prescribing provider requires prior authorization. No approved TAR present.	48	Referral/Authorization.
292	Denied by Special Claims Review – submitted documentation is illegible. Please resubmit with clearer writing or print.	294	Supporting documentation.
293	Denied by Special Claims Review – documentation submitted does not support additional payment (CIFs only).	294	Supporting documentation.
294	Insufficient or unavailable CCS county or GHPP fiscal year allocations; contact CCS/GHPP regional office.	9	No payment will be made for this claim.
295	Contracted facility ID provider number is required.	138	Entity's site ID.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
296	Non-contract facilities in a closed HFPA area require prior authorization from the date of admission.	84	Service not authorized.
297	This service is limited to once in nine months.	259	Frequency of service.
298	Reimbursement for initial comprehensive pregnancy-related office visit is limited to one in six months.	259	Frequency of service.
299	This accommodation code cannot be billed with any other accommodation code. Please resubmit split billing.	481	Claim/Submission format is invalid.
300	Acute level was billed; TAR does not authorize an acute level of care.	455	Revenue code for services rendered.
301	Kaiser denial is incomplete; resubmit with required Kaiser denial documentation.	286	Other payer's Explanation of Benefits/payment information.
302	Another procedure with an assistant surgeon modifier has been previously paid for same recipient on same date of service.	453	Procedure code modifier(s) for service(s) rendered.
303	Oxygen tanks in excess of two per 30 days require a valid TAR.	84	Service not authorized.
304	Accommodation/revenue code must be billed with appropriate admit type/procedure code.	454	Procedure code for services rendered.
305	This drug/NDC/medical supply/procedure should be billed under the listed code.	21	Missing or invalid information.
306	Recipient not eligible for Medi-Cal benefits without complete denial of coverage letter from American General.	286	Other payer's Explanation of Benefits/payment information.
307	CMSP recipients cannot be billed under contract provider ID number. Resubmit with non-contract provider ID number.	124	Entity's name, address, phone and ID number.
308	The Eligibility File indicates a possible recipient Share of Cost. Resubmit claim with a copy of the ID card.	294	Supporting documentation.
309	The recipient information does not match the Eligibility File. Contact the recipient's county welfare office to validate	21	Missing or invalid information.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	eligibility.		
310	Non-emergency CMSP services are not payable for aid code 50 recipients.	109	Entity not eligible.
311	Recipient is not eligible for Medi-Cal benefits without complete denial coverage statement from PHP/HMO.	286	Other payer's Explanation of Benefits/payment information.
312	The label unreadable or has the incorrect number of digits. Resubmit claim with a valid label.	21	Missing or invalid information.
313	Oxygen tanks in excess of two per month (30 days) require a valid TAR.	84	Service not authorized.
314	Recipient eligibility is not indicated for the month of service.	88	Entity not eligible for benefits for submitted dates of service.
315	The recipient information submitted on the claim does not match with eligibility information on file for this person.	21	Missing or invalid information.
316	Facility ID number required. Resubmit with nine-digit facility ID number.	138	Entity's site ID.
317	LTC Physician Recertification is missing.	21	Missing or invalid information.
318	Medicare number is not found on Provider Master File, contact DHCS Provider Enrollment Services.	131	Entity's Medicare provider ID.
319	Provider billing error. Second unilateral procedure not payable when billed twice in place of bilateral procedure codes.	454	Procedure code for services rendered.
320	Modifier -ZK is not valid for second/bilateral/multiple surgeries. Resubmit with correct modifier.	453	Procedure code modifier(s) for service(s) rendered.
321	Modifier -80 is not valid for multiple surgeries. Resubmit with modifier -99.	453	Procedure Code modifier(s) for service(s) rendered.
322	The anesthesia modifier billed on this claim is inappropriate. Resubmit with modifier -ZG.	453	Procedure Code modifier(s) for service(s) rendered.
323	Procedure is billed with incorrect modifier. Resubmit with	453	Procedure code modifier(s) for service(s) rendered.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	modifier -99.		
324	Procedure is billed with incorrect modifier. Resubmit with modifier -50.	453	Procedure code modifier(s) for service(s) rendered.
325	Procedure is billed with incorrect modifier. Resubmit with modifier -51.	453	Procedure code modifier(s) for service(s) rendered.
326	Another procedure with a primary surgeon modifier has been previously paid for same recipient on same date of service.	453	Procedure code modifier(s) for service(s) rendered.
327	LTC Physician Re-certification invalid. Please resubmit with valid re-certification.	21	Missing or invalid information.
328	Another procedure with an anesthesia modifier has been previously paid for the same recipient on the same date of service.	453	Procedure code modifier(s) for service(s) rendered.
329	TAR Control Number is invalid and claim cannot be processed via electronic billing.	48	Referral/Authorization.
330	Provider type is invalid for claim type. Resubmit with correct claim form or provider ID number.	481	Claim/Submission format is invalid.
331	Physician's statement section of the hysterectomy consent form is not complete.	294	Supporting documentation.
332	Recipient is not eligible for Medi-Cal benefits without complete denial of coverage letter from Blue Cross.	171	Other insurance coverage information (health, liability, auto, etc.).
333	Accommodation/revenue code billed was not found on Provider Master File. Contact DHCS Provider Enrollment Services.	455	Revenue code for services rendered.
334	Valid rate not on file for claim period of service. Contact DHCS Provider Enrollment Services.	122	Missing/Invalid data prevents payer from processing claim.
335	CMSP recipients are not eligible for Medicare crossover benefits. Contact the recipient's county eligibility office.	109	Entity not eligible.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
336	Procedure/category of service is not a benefit of CMSP.	454	Procedure code for services rendered.
337	Recipients with aid code 53 not eligible for inpatient services. Contact recipient's county eligibility office.	109	Entity not eligible.
338	This recipient is not eligible for Medi-Cal benefits. Contact the recipient's CMSP county eligibility office.	109	Entity not eligible.
339	Refractive component is processed via tape-to-tape; payment is denied.	9	No payment will be made for this claim.
340	The "through" date of service overlaps the CMSP contract effective date. This claim must be split-billed; resubmit.	481	Claim/Submission format is invalid.
341	Units of service billed exceed the TAR authorized days. Please resubmit with new TAR Control Number.	457	Non-covered day(s).
342	Multiple accommodation charges may be billed on one claim, but only one per discharge accommodation code is payable for each hospital discharge.	455	Revenue code for services rendered.
343	Unlisted and "By Report" DME requires manufacturer's name, catalog/model number, and a copy of manufacturer's catalog page showing suggested retail (i.e., list) price.	110	Claim requires pricing information.
344	Units of service billed exceed TAR authorized days due to per case/per diem combined billing. Resubmit with new TAR.	48	Referral/Authorization.
345	Facility ID number on claim does not match facility ID number on TAR. Resubmit with correct facility ID number.	138	Entity's site ID.
346	Provider ID number on claim does not match provider ID number on TAR. Resubmit with new TAR.	48	Referral/Authorization.
347	The facility provider ID number is not on the Provider Master File or is not an inpatient hospital provider number.	138	Entity's site ID.
348	Procedure billed is not payable in contracting facility for the date	454	Procedure code for services rendered.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	of service billed. Contact the facility.		
349	Admit date is within contract effective dates. Resubmit with contracting provider ID number.	124	Entity's name, address, phone and ID number.
350	Admit date is prior to contract effective date. Resubmit with non-contracting provider ID number.	124	Entity's name, address, phone and ID number.
351	Additional benefits are not warranted per Medi-Cal regulations.	9	No payment will be made for this claim.
352	Unlisted and "By Report" codes require description of services.	306	Detailed description of service.
353	Unlisted medical supplies and certain "By Report" procedures require manufacturer's name, catalog (item) number, and copy of manufacturer's catalog page (or supplier's invoice) showing wholesale price.	110	Claim requires pricing information.
354	The submitted CCS authorization is invalid.	48	Referral/Authorization.
355	Recipient is not eligible for Medi-Cal benefits without complete denial of coverage letter from Blue Shield.	286	Other payer's Explanation of Benefits/payment information.
356	Line item is denied. Tax not payable.	497	Tax not paid.
357	Wrong modifier was used in billing. Please check and rebill.	453	Procedure code modifier(s) for service(s) rendered.
358	Unlisted ambulance services require manufacturer's or supplier's invoice showing wholesale price.	110	Claim requires pricing information.
359	Hearing aid repairs are not payable without a copy of the repair facility invoice. Hearing aid purchases are not payable without the one-unit wholesale/acquisition cost attached to the claim.	110	Claim requires pricing information.
360	Allowance for postage and handling for repairs is payable only during the guarantee period.	9	No payment will be made for this claim.
361	These services were already paid by Medicare. Line item bill only Medicare non-covered services.	65	Claim/line has been paid.
362	Procedure number billed is not an authorized Medi-Cal code.	454	Procedure code for services rendered.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
363	This item not payable for patients in nursing homes.	9	No payment will be made for this claim.
364	The item billed can only be purchased.	9	No payment will be made for this claim.
365	The item billed can only be rented.	9	No payment will be made for this claim.
366	Originally paid at the lowest of MAIC, EAC, MAC, or charge to the general public.	104	Processed according to plan provisions.
367	Denied – RTD signature is missing/not original.	466	Entity's original signature.
368	Provider type is not acceptable for the Place of Service.	249	Place of service.
369	Medical transportation requires Emergency Statement or TAR.	21	Missing or invalid information.
370	Adjustment requires additional information.	21	Missing or invalid information.
371	Line detail crossover submitted incorrectly on Medi-Cal claim; submit only copy of Medicare claim and EOMB to Crossover Unit, P.O. Box 15700, Sacramento, CA, 95852-1700.	481	Claim/Submission format is invalid.
372	This crossover must be billed with line-specific information. Please resubmit with line item information.	21	Missing or invalid information.
373	Non-emergency services are not payable for limited service 200 % recipients.	9	No payment will be made for this claim.
374	Non-emergency services are not payable for limited service 133 % recipients.	9	No payment will be made for this claim.
375	EOMB is not attached; bill Medicare.	116	Claim submitted to incorrect payer.
376	Billed procedure code does not match TAR procedure code; new claim and/or TAR required.	48	Referral/Authorization.
377	This admission requires a TAR or a valid surgical procedure code.	21	Missing or invalid information.
378	Reimbursement information on this claim does not balance.	21	Diagnosis code(s) for the services rendered.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
379	This procedure/material falls within the six-month follow-up period and is not payable.	104	Processed according to plan provisions.
380	All services billed on this claim are denied due to the lack of prior authorization for a DME item.	84	Service not authorized.
381	Payment for this procedure has been included in a previously paid procedure for same date of service; no additional payment is warranted.	12	One or more originally submitted procedure codes have been combined.
382	You have inquired about the wrong line number of the CCN; please resubmit with the corrected CCN.	21	Missing or invalid information.
383	This is an incorrect format when requesting a tracer.	481	Claim/Submission format is invalid.
384	This is an incorrect format used for "from-through" billing.	481	Claim/Submission format is invalid.
385	Our records show that claim was in suspense at the time of inquiry; please inquire only on paid or denied claims.	0	Cannot provide further status electronically.
386	Two pairs of single vision lenses in lieu of multifocals require appropriate justification.	21	Missing or invalid information.
387	Plastic lenses require appropriate justification.	287	Medical necessity for service.
388	Bifocals for recipients under 38 years old require documentation.	294	Supporting documentation.
389	Documentation does not establish the medical necessity for procedure/appliance billed.	287	Medical necessity for service.
390	Please bill CCS; this service is not a covered benefit of the Medi-Cal program.	116	Claim submitted to incorrect payer.
391	Provider Master File shows rendering provider number/license number as suspended or deceased.	42	Entity's license/certification number.
392	Rendering provider ID number/license number not on file.	42	Entity's license/certification number.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
393	Death information for this beneficiary must be corrected by the Social Security Administration. Refer beneficiary to SSA.	21	Missing or invalid information.
394	This is a treatment period procedure that requires "from-thru" billing.	481	Claim/Submission format is invalid.
395	This is a Medicare non-covered benefit; rebill Medi-Cal on an original claim form, except for aid code 80 (QMB recipients)	481	Claim/Submission format is invalid.
396	Administrative days cannot be billed with any other accommodation codes.	455	Revenue code for services rendered.
397	Medicare residuals cannot be billed with non-covered/denied Medicare services.	9	No payment will be made for this claim.
398	Recipient is on restricted services. An approved TAR or emergency statement is required.	84	Service not authorized.
399	Refractive component processed via tape-to-tape; payment is denied.	9	No payment will be made for this claim.
400	Documentation is not adequate for additional benefits. Additional information required. Submit a copy of original claim, copy of RADs that reflect payment or denial for the claim involved and any additional supporting documents.	294	Supporting documentation.
401	Payment was adjusted to maximum allowable.	67	Payment made in full.
402	Paid in accordance with Drug Advisor.	67	Payment made in full.
403	Paid in accordance with Medi-Cal laws and regulations.	67	Payment made in full.
404	Payment reduced to cost of ingredient due to billing frequency limitations.	259	Frequency of service.
405	Reduced by Dialysis Obligation.	68	Partial payment made for this claim.
406	Payment is reduced due to other insurance payment.	68	Partial payment made for this claim.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
407	Reduced by Dialysis Obligation or Other Coverage.	68	Partial payment made for this claim.
408	Payment reduced because of patient liability (Share of Cost).	68	Partial payment made for this claim.
409	Payment is adjusted to authorized principal labeler.	68	Partial payment made for this claim.
410	Paid in accordance with Peer Review.	47	Internal review/audit. Partial payment made.
411	Payment reduced to the Cost of Ingredient because drug does not meet the 100 minimum quantity limitation.	104	Processed according to plan provisions.
412	Medi-Cal maximum was paid by other insurance.	67	Payment made in full.
413	Payment was reduced because recipient used the maximum leave days allowed.	498	Maximum leave days exhausted.
414	Payment was reduced by Medical Review.	47	Internal review/Audit. Partial payment made.
415	Procedure which normally is done in the office is payable at 80 % of allowable charge when done in an outpatient or surgical clinic environment.	104	Processed according to plan provisions.
416	Split-billing indicator on the Provider Master File has caused a cutback per the split-billing agreement.	104	Processed according to plan provisions.
417	Billed amount is cutback to allowed amount per the Accommodation Rate File, or to disallow payment for the day of discharge or death.	104	Processed according to plan provisions.
418	Payment was reduced by the amount of related procedure already paid.	12	One or more originally submitted procedure codes have been combined.
419	Payment reduced by Special Claims Review to the level of service substantiated by the documentation submitted.	47	Internal review/Audit. Partial payment made.
420	Payment was reduced by Special Claims Review for ancillary services to the level of service substantiated by documentation submitted.	47	Internal review/Audit. Partial payment made.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
421	Payment was reduced to a zero allowable as a denial by Medical Review.	46	Internal review/Audit.
422	The "By Report" claim/RNE procedure payment was reduced to the nearest appropriate procedure by Medical Review.	47	Internal review/Audit. Partial payment made.
423	Payment was reduced in accordance with the service limit set for this procedure.	104	Processed according to plan provisions.
424	Undeliverable custom-made appliances payable at 80 percent.	104	Processed according to plan provisions.
425	Payment was reduced for CPT-4 code 92014 billed within three months of CPT-4 code 99201 or 99212.	104	Processed according to plan provisions.
426	Paid in accordance with Vision Care Advisor.	47	Internal review/Audit. Partial payment made.
427	No hourly rate is on file for this CHFC accommodation code. Contact DHCS Provider Enrollment. Hourly rate not applicable to UB-92 codes.	499	No rate on file with the payer for this service for this entity.
428	One per-discharge accommodation rate is payable per hospital discharge.	104	Processed according to plan provisions.
429	Negative non-covered amount.	9	No payment will be made for this claim.
430	Metal or combination frames are insufficiently justified; payment is reduced to the amount allowable for zyle frame.	294	Supporting documentation.
431	Reduced payment because of non-covered charges.	104	Processed according to plan provisions.
432	Documentation does not justify the level of care billed and is being reduced by Medical Review.	47	Internal review/Audit. Partial payment made.
433	Payment reduced because of patient liability (Share of Cost).	68	Partial payment made for this claim.
434	Payment was determined by Medical Review.	47	Internal review/Audit. Partial payment made.
435	The quantity billed for procedure exceeds usual practice	258	Days/Units for procedure/revenue code.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
436	The payment was reduced in accordance with recipient's percentage obligation.	68	Partial payment made for this claim.
437	This claim has been paid at the TAR-authorized amount.	67	Payment made in full.
438	Price reduced in accordance with maximum quantity allowed.	258	Days/Units for procedure/revenue code.
439	Reimbursement amount prorated for automated chemistry test.	104	Processed according to plan provisions.
440	Prior authorization required for oxygen (E0441) when more than two tanks are provided during one calendar month.	84	Service not authorized.
441	Reimbursement is limited to \$150 for all urodynamic procedures rendered on one day of service.	104	Processed according to plan provisions.
442	Medicare payment meets or exceeds Medi-Cal maximum reimbursement.	67	Payment made in full.
443	Medi-Cal payment may not exceed the maximum amount allowed by Medi-Cal.	104	Processed according to plan provisions.
444	For non-physician claims, see Charpentier billing instructions in the provider manual. Medi-Cal automated system payment does not exceed the Medicare allowed amount.	104	Processed according to plan provisions.
445	Payment is based on the cost of unlisted miscellaneous supplies usually required for this service.	66	Payment reflects usual and customary charges.
446	Reimbursement for urodynamic studies reduced to meet maximum allowed.	104	Processed according to plan provisions.
447	These services not allowed when billed in conjunction with administrative days; rebill using an outpatient claim form.	455	Revenue code for services rendered.
448	These services are not allowed when billed in conjunction with administrative days.	104	Processed according to plan provisions.
449	Medi-Cal payment for eye refraction.	67	Payment made in full.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
450	Payment reduced by Special Claims Review – submitted documentation is incomplete. Resubmit with all the required documentation copied on only one side of the paper.	47	Internal review/Audit. Partial payment made.
451	Payment reduced by Special Claims Review to the level of an initial or established patient office visit supported by the documentation submitted. The submitted documentation does not support a preventive health care visit.	47	Internal review/Audit. Partial payment made.
452	Ancillary charges are required for billing, but are not payable for contracted hospitals.	9	No payment will be made for this claim.
453	Payment was reduced to zero due to inadequate justification for hospital late stay.	287	Medical necessity for service.
456	Reduced by audit.	46	Internal review/Audit.
457	Nopay ancillary S-VNT.	9	No payment will be made for this claim.
458	Nopay ancillary S-NVNT.	9	No payment will be made for this claim.
459	Aid codes 7F and 7G are reimbursed at the lowest level office visit rate for established or new patient office visits.	67	Payment made in full.
460	The claim was paid one administration fee for this injection.	104	Processed according to plan provisions.
461	Surgical reimbursement reduced by the amount paid in history for a pre-operative visit, same day or one day prior to surgery.	12	One or more originally submitted procedure codes have been combined.
462	Administrative fee reimbursement was reduced not to exceed maximum payable amount per month.	104	Processed according to plan provisions.
463	Payment was cutback to not exceed the monthly/yearly services cap for this AIDS Waiver recipient.	104	Processed according to plan provisions.
465	Additional reimbursement was approved based on substantiated justification.	65	Claim/line has been paid.
466	Ancillary charges billed in conjunction with administrative days	104	Processed according to plan provisions.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	were paid at the interim reimbursement rate.		
467	Payment is reduced to the level of CPT-4 code 76815.	13	All originally submitted procedure codes have been modified.
468	Payment reduced to a lower level of care.	13	All originally submitted procedure codes have been modified.
469	Payment was reduced to zero as Medi-Cal's maximum reimbursement equals Medicare's payment on this claim.	9	No payment will be made for this claim.
470	Allowed amount determined by Medical Review.	46	Internal review/Audit.
471	Operating room (Z7506) is payable at treatment room level, and operating room (Z7508/Z7510) or recovery room (Z7512) is payable at zero when surgery other than a common office procedure was not billed for this patient on the same date of service.	15	One or more originally submitted procedure codes have been modified.
472	Billed procedure or modifier code was translated to the HCPCS coding scheme.	15	One or more originally submitted procedure code have been modified
473	Billed procedure or modifier code translated to HCPCS coding scheme and cutback.	15	One or more originally submitted procedure code has been modified.
474	Disproportionate share code billed was cutback to zero due to Senate Bill 855.	9	No payment will be made for this claim.
475	Claims received during the 7th – 9th month after the month of service without a valid limit exception are reduced to 75% of the allowed amount.	104	Processed according to plan provisions.
476	Claims received during the 10th – 12th month after the month of service without a valid limit exception are reduced to 50% of the allowed amount.	104	Processed according to plan provisions.
477	CMSP reduction was cutback.	104	Processed according to plan provisions.
478	Ancillary is included in accommodation rate. Rate adjustment is not to exceed California average contract hospital rate. Ancillary is required for billing.	104	Processed according to plan provisions.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
479	Payment is based on supplies and drugs commonly used for this procedure.	66	Payment reflects usual and customary charges.
480	The procedure billed exceeded the service limitation and was reduced to the value of 90040 or 99212.	14	Some all originally submitted procedure codes have been modified.
481	The procedure billed exceeded the service limitation and was reduced to the value of 90050 or 99213.	14	Some all originally submitted procedure codes have been modified.
482	The procedure billed exceeded the service limitation and was reduced to the value of 90060 or 99214.	14	Some all originally submitted procedure codes have been modified.
483	The procedure billed exceeded the service limitation and was reduced to the value of 90761 or 99394.	14	Some all originally submitted procedure codes have been modified.
484	The procedure billed exceeded the service limitation and was reduced to the value of 90762 or 99393.	14	Some all originally submitted procedure codes have been modified.
485	The procedure billed exceeded the service limitation and was reduced to the value of 90200 or 99221.	14	Some all originally submitted procedure codes have been modified.
486	The procedure billed exceeded the service limitation and was reduced to the value of 90763 or 99392.	14	Some all originally submitted procedure codes have been modified.
487	The procedure billed exceeded the service limitation and was reduced to the value of 90540 or 99282.	14	Some all originally submitted procedure codes have been modified.
488	The payment was reduced to the level of CPT-4 code 90550 or 99282.	14	Some all originally submitted procedure codes have been modified.
489	The procedure billed exceeded the service limitation and was reduced to the value of 90764 or 99391.	14	Some all originally submitted procedure codes have been modified.
490	The procedure billed exceeded the service limitation and was reduced to the value of Z1210 or 58608.	14	Some all originally submitted procedure codes have been modified.
491	The procedure billed exceeded the service limitation and was reduced to the value of 90530 or 99281.	14	Some all originally submitted procedure codes have been modified.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
492	The procedure billed exceeded the service limitation and was reduced the value of 90570 or 99282.	14	Some all originally submitted procedure codes have been modified.
493	The procedure billed exceeded the service limitation and was reduced to the value of X9958, 99262 or 99215.	14	Some all originally submitted procedure codes have been modified.
494	The procedure billed exceeded the service limitation and was reduced to the value of X9960 or 99263.	14	Some all originally submitted procedure codes have been modified.
495	The procedure billed exceeded the service limitation and was reduced to the value of 90580 or 99282.	14	Some all originally submitted procedure codes have been modified.
496	The procedure billed exceeded the service limitation and was reduced to the value of 90070 or 99214.	14	Some all originally submitted procedure codes have been modified.
497	Payment reduced to the level of CPT-4 code 99283.	14	Some all originally submitted procedure codes have been modified.
498	The procedure billed exceeded the service limitation and was reduced to the value of 99241.	14	Some all originally submitted procedure codes have been modified.
500	EDS-initiated retroactive rate correction.	101	Claim was processed as adjustment to previous claim.
501	Adjustment due to State Controller's audit.	46	Internal review/Audit.
502	EDS initiated adjustment as a result of a prior overpayment.	101	Claim was processed as adjustment to previous claim.
503	EDS initiated adjustment as a result of a prior underpayment.	101	Claim was processed as adjustment to previous claim.
504	EDS initiated adjustment due to a change in the claim date of service.	101	Claim was processed as adjustment to previous claim.
505	EDS initiated adjustment as a result of a change in the drug/ NDC/service code.	101	Claim was processed as adjustment to previous claim.
506	EDS initiated adjustment as a result of 80 % cutback overpayment.	101	Claim was processed as adjustment to previous claim.
507	EDS initiated void; claim paid under non-contract provider ID;	124	Entity's name, address, phone and ID number.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	please submit a new claim with contract provider ID.		
508	EDS initiated adjustment for payment made for wrong recipient, and the right recipient is not eligible.	109	Entity not eligible.
509	Adjustment due to an inappropriate payment made for a service rendered on a denied acute (inpatient) day.	104	Processed according to plan provisions.
510	EDS initiated adjustment as a result of a change in the quantity or number of occurrences per drug/NDC/service code.	101	Claim was processed as adjustment to previous claim.
511	EDS initiated adjustment as a result of a change in the number of estimated days supplied or number of days authorized.	101	Claim was processed as adjustment to previous claim.
512	EDS initiated adjustment as a result of a change in the recipient's other coverage.	101	Claim was processed as adjustment to previous claim.
513	EDS initiated adjustment as a result of a change in the provider's eligibility status.	101	Claim was processed as adjustment to previous claim.
514	EDS initiated adjustment as a result of a change in the recipient's eligibility status.	101	Claim was processed as adjustment to previous claim.
515	EDS initiated adjustment as a result of a change in the attending, referring, or prescribing provider ID.	101	Claim was processed as adjustment to previous claim.
516	EDS initiated adjustment as a result of a change in the accommodation/revenue code.	101	Claim was processed as adjustment to previous claim.
517	EDS initiated adjustment as a result of a change in patient's status code when it was not previously appropriate for the accommodation/revenue code.	101	Claim was processed as adjustment to previous claim.
518	EDS initiated adjustment as a result of a change in the diagnosis code.	101	Claim was processed as adjustment to previous claim.
519	EDS initiated adjustment as a result of a change in the level of care code.	101	Claim was processed as adjustment to previous claim.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
520	EDS initiated adjustment as a result of a claim that was erroneously denied.	101	Claim was processed as adjustment to previous claim.
521	EDS initiated adjustment as a result of a change in the original claims decision due to the receipt of additional information.	101	Claim was processed as adjustment to previous claim.
522	Payment void; wrong provider ID.	124	Entity's name, address, phone and ID number.
523	Payment void; wrong recipient ID.	153	Entity's ID number.
524	EDS initiated retroactive reprocessing.	101	Claim was processed as adjustment to previous claim.
526	Provider personal check adjusted.	101	Claim was processed as adjustment to previous claim.
528	Adjustment due to returned provider check.	101	Claim was processed as adjustment to previous claim.
530	State initiated retroactive rate correction.	101	Claim was processed as adjustment to previous claim.
531	State initiated inadvertently paid to wrong provider.	101	Claim was processed as adjustment to previous claim.
532	State initiated adjustment as a result of a prior overpayment.	101	Claim was processed as adjustment to previous claim.
533	State initiated adjustment as a result of a prior underpayment.	101	Claim was processed as adjustment to previous claim.
534	State initiated adjustment as a result of a change in the claim date of service.	101	Claim was processed as adjustment to previous claim.
535	State initiated adjustment as a result of a change in the claim drug/NDC/service code.	101	Claim was processed as adjustment to previous claim.
536	DHCS initiated void as a result of the through date of service overlapping the CMSP contract effective date. This claim must be split-billed; resubmit.	197	Effective coverage date(s).
537	State initiated void; claim paid under non-contract provider ID. Please submit a new claim with contract provider ID.	124	Entity's name, address, phone and ID number.
538	State initiated adjustment for payment made for wrong recipient and the right recipient is not eligible.	109	Entity not eligible.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
539	State initiated adjustment as a result of an appeal.	101	Claim was processed as adjustment to previous claim.
540	State initiated adjustment as a result of a change in quantity or number of occurrences per drug/NDC/service code.	101	Claim was processed as adjustment to previous claim.
541	State initiated adjustment as a result of a change in the number of estimated days supplied or the number of days authorized.	101	Claim was processed as adjustment to previous claim.
542	State initiated adjustment due to a change in the recipient's other coverage.	101	Claim was processed as adjustment to previous claim.
543	State initiated adjustment as a result of a change in the provider's eligibility status.	101	Claim was processed as adjustment to previous claim.
544	State initiated adjustment as a result of a change in the recipient's eligibility status.	101	Claim was processed as adjustment to previous claim.
545	State initiated adjustment as a result of a change in the attending, prescribing, or referring provider ID.	101	Claim was processed as adjustment to previous claim.
546	State initiated adjustment as a result of a change in the accommodation/revenue code.	101	Claim was processed as adjustment to previous claim.
547	State initiated adjustment as a result of change in patient's status code when it was not previously appropriate for the accommodation/revenue code.	101	Claim was processed as adjustment to previous claim.
548	State initiated adjustment as a result of a change in the diagnosis code.	101	Claim was processed as adjustment to previous claim.
549	State initiated adjustment as a result of a change in the level of care code.	101	Claim was processed as adjustment to previous claim.
550	State initiated void; this service is not a benefit of Medi-Cal on the date of service billed.	88	Entity not eligible for benefits for submitted dates of service.
551	State initiated adjustment as a result of change in the original claims decision due to the receipt of additional information.	101	Claim was processed as adjustment to previous claim.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
552	Payment void; wrong provider ID.	124	Entity's name, address, phone and ID number.
553	Payment void; wrong recipient ID.	153	Entity's ID number.
554	Occidental initiated Medicare crossover adjustment.	101	Claim was processed as adjustment to previous claim.
555	Blue Shield initiated Medicare crossover adjustment.	101	Claim was processed as adjustment to previous claim.
556	Adjustment A/C appeal.	101	Claim was processed as adjustment to previous claim.
557	Medicare appeals project; Medi-Cal overpayment.	101	Claim was processed as adjustment to previous claim.
560	EDS initiated void retroactive adjustment.	101	Claim was processed as adjustment to previous claim.
561	EDS initiated voided retroactive duplicate CCN.	101	Claim was processed as adjustment to previous claim.
562	EDS initiated retroactive reprocessing.	101	Claim was processed as adjustment to previous claim.
563	Retroactive reprocessing.	101	Claim was processed as adjustment to previous claim.
564	Retroactive reprocessing.	101	Claim was processed as adjustment to previous claim.
565	EDS initiated crossover reprocessing.	101	Claim was processed as adjustment to previous claim.
567	Provider initiated adjustment or void due to a change in the Share of Cost information.	101	Claim was processed as adjustment to previous claim.
570	EDS initiated recoupment of paid services provided during PSRO denied hospitalization days.	101	Claim was processed as adjustment to previous claim.
571	Adjustment due to State Controller's audit.	46	Internal review/Audit.
572	Provider initiated adjustment as a result of an overpayment.	101	Claim was processed as adjustment to previous claim.
573	Provider initiated adjustment as a result of an underpayment.	101	Claim was processed as adjustment to previous claim.
574	Provider initiated adjustment as a result of a change in the claim date of service.	101	Claim was processed as adjustment to previous claim.
575	Provider initiated adjustment as a result of a change in the drug/	101	Claim was processed as adjustment to previous claim.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	NDC/service code.		
577	Healthy Family retroactive adjustment.	101	Claim was processed as adjustment to previous claim.
578	Adjustment due to CCS audit.	46	Internal review/Audit.
579	Adjustment due to CHDP audit.	46	Internal review/Audit.
580	Provider initiated adjustment as a result of a change in the quantity or number of occurrences per drug/NDC/service code.	101	Claim was processed as adjustment to previous claim.
581	Provider initiated adjustment as a result of a change in the number of estimated days supplied or number of days authorized.	101	Claim was processed as adjustment to previous claim.
582	Provider initiated adjustment due to a change in the recipient's other coverage.	101	Claim was processed as adjustment to previous claim.
583	Provider initiated adjustment as a result of a change in the provider's eligibility status.	101	Claim was processed as adjustment to previous claim.
584	Provider initiated adjustment as a result of a change in the recipient's eligibility status.	101	Claim was processed as adjustment to previous claim.
585	Provider initiated adjustment as a result of a change in the attending, prescribing or referring provider ID.	101	Claim was processed as adjustment to previous claim.
586	Provider initiated adjustment as a result of a change in the accommodation/revenue code.	101	Claim was processed as adjustment to previous claim.
587	Provider initiated adjustment as a result of a change in the patient's status code when it was not previously appropriate for the accommodation/revenue code.	101	Claim was processed as adjustment to previous claim.
588	Provider initiated adjustment as a result of a change in the diagnosis code.	101	Claim was processed as adjustment to previous claim.
589	Provider initiated adjustment as a result of a change in the level of care code.	101	Claim was processed as adjustment to previous claim.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
590	Provider initiated adjustment as a result of a claim that was erroneously denied.	101	Claim was processed as adjustment to previous claim.
591	Provider initiated adjustment as a result of a change in the original claim decision due to receipt of additional information.	101	Claim was processed as adjustment to previous claim.
592	Payment void; wrong provider ID.	124	Entity's name, address, phone and ID number.
593	Payment void; wrong recipient ID.	153	Entity's ID number.
594	Occidental initiated Medicare crossover adjustment.	101	Claim was processed as adjustment to previous claim.
595	Blue Shield initiated Medicare crossover adjustment.	101	Claim was processed as adjustment to previous claim.
596	Blue Shield initiated Medicare crossover void.	101	Claim was processed as adjustment to previous claim.
597	Occidental initiated Medicare crossover void.	101	Claim was processed as adjustment to previous claim.
598	EDS initiated adjustment as a result of incorrect payment associated with a returned warrant which has been redeposited by the State.	101	Claim was processed as adjustment to previous claim.
599	EDS initiated adjustment as a result of an over/underpayment associated with a returned warrant which has been redeposited by the State.	101	Claim was processed as adjustment to previous claim.
601	Pending return of <i>Resubmission Turnaround Document</i> .	23	Returned to entity.
602	Pending adjudication.	20	Accepted for processing.
603	Pending EDS review.	46	Internal review/Audit.
604	Pending eligibility confirmation.	56	Awaiting eligibility determination.
605	Pending validation of <i>Treatment Authorization Request Control Number</i> .	252	Authorization/Certification number.
606	Pending administrative or medical review.	46	Internal review/Audit.
607	Pending Share of Cost State review.	46	Internal review/Audit.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
608	Medi-Cal paid full cost sharing on the part B crossover claim.	67	Payment made in full.
609	Invalid BIC. A new BIC was issued.	21	Missing or invalid information.
610	Not authorized to electronically bill CCS or GHPP services. Resubmit hard copy claim to CCS/GHPP program office for approval.	24	Entity not approved as an electronic submitter.
611	The TAR attached to your CIF or appealed claim is unreadable or illegible.	48	Referral/Authorization.
612	Procedure found in history with a similar modifier for the same date of service; this constitutes a duplicate.	54	Duplicate of a previously processed claim/line.
613	The PM 160 form was not attached to the claim; resubmit with the PM 160.	294	Supporting documentation.
614	Recipient county is not a CHDP treatment program contract-back county or not contract-back county on date of service.	107	Processed according to contract/plan provisions
615	The attached PM 160 is missing a county code, or other information, or is illegible, or a new condition with referral was not detected.	21	Missing or invalid information.
616	The recipient name, sex, and/or date of birth on the claim do not correspond to the attached PM 160 form.	21	Missing or invalid information.
617	Medical justification is not present or does not substantiate follow-up treatment beyond 90 days from the CHDP screening.	287	Medical necessity for service.
618	CHDTP benefits are not payable for patients over 18 years of age, or for dates of service prior to July 1, 1990.	109	Entity not eligible.
619	This service is included in another procedure code billed within six months of date of service.	259	Frequency of service.
620	Claims were recycled the maximum number of times.	9	No payment will be made for this claim.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	Information requested from provider on deferred TAR has not been received.		
621	The monthly/yearly limit for this procedure has been exceeded; claim is denied.	259	Frequency of service.
622	Coinsurance and deductible are not separately payable on inpatient stay of Medicare Part-B only covered recipient.	104	Processed according to plan provisions.
623	Claim was denied due to the Other Health Coverage having paid in full, or the OHC payment exceeding the Medi-Cal allowed amount.	104	Processed according to plan provisions.
624	Non-emergency services are not payable for limited scope 100 % recipients.	109	Entity not eligible.
625	A CIF cannot be used to request resubmission of a denied claim if the inpatient provider also wants to add or delete claim lines.	481	Claim/Submission format is invalid.
626	Non-emergency related services are not payable for aid code 55 recipients.	109	Entity not eligible.
627	The inpatient days or dates of service billed on the claim do not match the CCS Authorization Form.	187	Date(s) of service.
628	The provider/recipient IDs or the service billed is not consistent with the CCS Authorization Form.	48	Referral/Authorization.
629	Surgery other than a common office procedure was not billed for this patient on the same date of service. Operating room payable at treatment room level or at zero. Recovery room payable at zero.	9	No payment will be made for this claim.
630	The submitted documentation was not adequate. The length of time actually spent monitoring the service must be indicated.	294	Supporting documentation.
631	TAR authorized psychotherapy services have been previously	84	Service not authorized.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	paid. Non-TAR services are not payable for the same period of time as TAR-authorized services.		
632	Invalid disproportionate share code for dates of service on or after July 1, 1992. Chapter 279/SB 855. Chapter 1046/SB 146.	21	Missing or invalid information.
633	TPN/compound prescription documentation is incomplete or incorrect. A letter has been sent to the address on the claim indicating needed the correction.	2	More detailed information in letter.
634	CLIA laboratory number is not on file for lab procedure on date of service. Contact Provider Enrollment Services.	21	Missing or invalid information.
635	The statement of medical necessity requires a physician's signature.	466	Entity's original signature.
636	Medi/Medi-Charpentier claim does not meet submission requirements. Verify that the correct codes were used; dates of service match (EOMB, MRN), and EOMB/MRN and Medi-Cal RADs are attached.	21	Missing or invalid information.
637	Maximum allowed per month has been paid; medical justification is required for additional dialysis visits.	287	Medical necessity for service.
638	Rendering provider is missing or invalid.	21	Missing or invalid information.
639	Recipient not eligible for Medi-Cal benefits without complete denial of coverage letter from Prudential.	286	Other payer's Explanation of Benefits/payment information.
640	Recipient is not eligible for Medi-Cal benefits without complete denial of coverage from Medicare HMO, CMP or HCPP. Recipient must use the plan provider.	286	Other payer's Explanation of Benefits/payment information.
641	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Mutual of Omaha.	286	Other payer's Explanation of Benefits/payment information.
642	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Metropolitan Life.	286	Other payer's Explanation of Benefits/payment information.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
643	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from John Hancock Mutual Life.	286	Other payer's Explanation of Benefits/payment information.
644	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Equicor/Equitable.	286	Other payer's Explanation of Benefits/payment information.
645	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Travelers.	286	Other payer's Explanation of Benefits/payment information.
646	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Connecticut General CIGNA.	286	Other payer's Explanation of Benefits/payment information.
647	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from private insurance carrier.	286	Other payer's Explanation of Benefits/payment information.
648	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Great West Life Assurance.	286	Other payer's Explanation of Benefits/payment information.
649	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Provident Life and Accident.	286	Other payer's Explanation of Benefits/payment information.
650	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Principal Financial Group.	286	Other payer's Explanation of Benefits/payment information.
651	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Pacific Mutual Life Insurance.	286	Other payer's Explanation of Benefits/payment information.
652	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Alta Health Strategies.	286	Other payer's Explanation of Benefits/payment information.
653	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from AARP.	286	Other payer's Explanation of Benefits/payment information.
654	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from Allstate Life Insurance.	286	Other payer's Explanation of Benefits/payment information.
655	Recipient not eligible for Medi-Cal benefits without complete denial of coverage from New York Life Insurance.	286	Other payer's Explanation of Benefits/payment information.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
656	Recipient not eligible for Medi-Cal benefits without proof of denial of coverage from the Healthy Families Program. Call 1-800-880-5305 for more information.	286	Other payer's Explanation of Benefits/payment information.
657	Recipient not eligible for Medi-Cal benefits until payment or denial information is given from other insurance carrier.	286	Other payer's Explanation of Benefits/payment information.
659	System unavailable.	0	Cannot provide further status electronically.
660	Submitter inactive.	24	Entity not approved as an electronic submitter.
661	Invalid software version.	481	Claim/submission format is invalid.
662	Invalid submitter.	24	Entity not approved as an electronic submitter.
663	Attachments or comments are required; please resubmit hardcopy.	294	Supporting documentation.
665	The days' supply billed exceeds the days' supply limit.	259	Frequency of service.
666	This claim exceeds \$599.99 per calendar year or 10 claim lines per calendar year.	104	Processed according to plan provisions.
667	The date of issue entered does not match.	21	Missing or invalid information.
668	The prescription number is a duplicate of a previously paid claim.	54	Duplicate of a previously processed claim/line.
669	Fee For Service/Managed Care Network referral authorization has expired; contact FFS/MCN plan.	48	Referral/Authorization.
670	Fee For Service/Managed Care Network Referral Authorization Form required for FFS/MCN plan service rendered by a non-FFS/MCN provider. Contact FFS/MCN plan.	48	Referral/Authorization.
671	State initiated reprocessing of claim; this claim has been assigned a new CCN.	101	Claim was processed as adjustment to previous claim.
672	This claim exceeds the monthly reimbursement limit for	259	Frequency of service.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
	incontinence supplies.		
673	The claim exceeds the prescription limit and requires a TAR.	84	Service not authorized.
674	Discharge rate not payable if readmitted within 24 hours for the same or related condition.	9	No payment will be made for this claim.
675	Fee For Service/Managed Care Network Referral Authorization Form number does not match claim. Verify RAF number on claim and contact the FFS/MCN plan if necessary.	48	Referral/Authorization.
676	Outcome data for BCEDP claims (Aid Code 9A) must be listed for each procedure code.	21	Missing or invalid information.
677	Denied by Special Claims Review; this service is reimbursed under another procedure.	9	No payment will be made for this claim.
678	Denied by Special Claims Review; electronic billing is not appropriate for services that require supporting documentation.	481	Claim/Submission format is invalid.
679	CTP payment reduction.	104	Processed according to plan provisions.
680	EAPC claims for CHDP health assessment are not payable when patient has paid a Share of Cost.	9	No payment will be made for this claim.
681	EAPC claims are not payable when a patient has other coverage or has full scope Medi-Cal coverage.	9	No payment will be made for this claim.
682	Provider not on EAPC or MSSP file, or grant amount for fiscal year exceeded.	122	Missing/Invalid data prevents payer from processing claim.
683	CPSP initial comprehensive code Z6500 and any initial individual assessment code (Z6200, Z6300 or Z6402) are not reimbursed in conjunction with each other.	104	Processed according to plan provisions.
684	Non-capitated inpatient psychiatric mental health services for a PCCM recipient requires an approved TAR Form 18-3 from the County Mental Health Plan.	84	Service not authorized.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
685	Ancillary charges are required for billing but are not separately reimbursable. Use other non-contract, non-HSM provider ID to bill take-home drugs with Medicare deductibles and coinsurance.	9	No payment will be made for this claim.
686	Resubmit with attached anesthesia report indicating or certifying actual time spent with patient.	251	Total anesthesia minutes.
687	"By-Report" custom-made orthotic and prosthetic appliances require a copy of the original invoice for the materials/parts used in preparing the device, or the manufacturer's catalog page showing the suggested retail price of the materials.	110	Claim requires pricing information.
688	Daily and monthly services are not separately reimbursable for same recipient in the same calendar month.	104	Processed according to plan provisions.
689	Check the CDS application for missing data (breast symptoms, provider ID, recipient name, recipient ID); check claim line for outcome code.	21	Missing or invalid information.
690	CCS authorization invalid.	48	Referral/Authorization.
691	Diagnosis code is invalid for date of service.	255	Diagnosis code.
692	Outpatient and emergency services during an inpatient stay are not separately reimbursable per facility contract.	107	Processed according to contract/plan provisions.
693	Other coverage code is missing or invalid.	21	Missing or invalid information.
694	Only one BCEDP case management code is reimbursable on the same date of service.	259	Frequency of service.
695	Ancillary charges are required for billing, but not separately payable for transitional care providers.	9	No payment will be made for this claim.
696	Code 1 duration of drug/medical supply therapy limitation has been exceeded.	104	Processed according to plan provisions.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
697	The frequency of billing limitation for this drug/medical supply has been exceeded.	259	Frequency of service.
698	Claim was sent to EDS in error; submit to CCS office in county where recipient resides.	116	Claim submitted to incorrect payer.
699	Procedure Z2503 is payable only once in 140 days. Codes 59000, 82106, 88261, 88262, 88263, 88267, 88269 and 88280 require a TAR if Z2503 has been paid within the previous 84 days.	259	Frequency of service.
701	Regulatory withhold as a result of delinquent cost report.	104	Processed according to plan provisions.
702	Payment of accumulated regulatory withhold amount as the delinquent cost report has been received.	46	Internal review/Audit.
703	Provider payment received and applied to tentative cost settlement principal and interest amounts.	6	Balance due from the subscriber.
704	Provider payment received and applied to final cost settlement principal and interest amounts.	6	Balance due from the subscriber.
705	Provider payment received and applied to revised cost settlement principal and interest amounts.	6	Balance due from the subscriber.
706	Tentative cost settlement principal and interest amounts withheld.	6	Balance due from the subscriber.
707	Final cost settlement principal and interest amounts withheld.	6	Balance due from the subscriber.
708	Revised cost settlement principal and interest amounts withheld.	6	Balance due from the subscriber.
709	Payment to provider of tentative cost settlement.	68	Partial payment made for this claim.
710	Payment to provider of final cost settlement.	67	Payment made in full.
711	Payment to provider of revised cost settlement.	67	Payment made in full.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
712	Amount withheld in accordance with repayment agreement.	6	Balance due from the subscriber.
713	Provider payment received in accordance with repayment agreement.	6	Balance due from the subscriber.
714	Amount withheld for a negative balance transferred to accounts receivable.	6	Balance due from the subscriber.
715	Amount withheld for recoupment of interim or advance payments.	6	Balance due from the subscriber.
716	Provider check in payment of an accounts receivable resulting from claims overpayment.	6	Balance due from the subscriber.
717	Amount withheld as a result of a State audit or investigation.	46	Internal review/Audit.
718	Interest refund.	104	Processed according to plan provisions.
719	Interest charge.	6	Balance due from the subscriber.
720	Amount withheld as a result of provider debt other than cost settlement or claims overpayment.	6	Balance due from the subscriber.
721	Amount received and deducted from amount owed as a result of provider debt other than cost settlement or claims overpayment.	6	Balance due from the subscriber.
722	Reduction of the final settlement due to the State as a result of an appeal settlement.	6	Balance due from the subscriber.
723	Amount paid due to Andriola v. Kizer repayment.	104	Processed according to plan provisions.
724	Provider check received without explanation; EDS research.	20	Accepted for processing.
725	Provider check received with explanation; applied.	20	Accepted for processing.
726	Amount withheld for recoupment; restricted prescribing provider.	6	Balance due from the subscriber.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
727	Reissue of a returned or redeposited warrant.	104	Processed according to plan provisions.
728	Payment to provider of an amount due resulting from other than a cost settlement.	104	Processed according to plan provisions.
729	Account receivable transaction to transfer the negative balance amount to an account receivable.	6	Balance due from the subscriber.
730	Amount withheld as a result of a claims overpayment.	6	Balance due from the subscriber.
731	Increase in the final settlement due to State as a result of an appeal settlement.	6	Balance due from the subscriber.
732	Amount withheld in accordance with State instructions.	104	Processed according to plan provisions.
733	Provider personal check applied to Rate Development Branch cost settlement.	6	Balance due from the subscriber.
734	System withhold resulting from a Rate Development Branch cost settlement.	6	Balance due from the subscriber.
735	Provider payment received as a result of State audit or investigation.	46	Internal review/Audit.
736	Payment to provider of funds withheld per State instruction.	104	Processed according to plan provisions.
737	Accounts receivable payment to repay "adjustment 822" of checkwrite 1-11-90.	6	Balance due from the subscriber.
738	Adjustment to increase a provider's earnings (1099 information).	104	Processed according to plan provisions.
739	Adjustment to decrease a provider's earnings (1099 information).	104	Processed according to plan provisions.
740	Interim payment authorized by DHCS.	68	Partial payment made for this claim.
741	Adjustment to decrease provider's earnings personal check (1099).	104	Processed according to plan provisions.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
742	SB 855 disproportionate share payment for 1991/1992.	68	Partial payment made for this claim.
743	Federally qualified health center cost settlement payment.	68	Partial payment made for this claim.
744	Fountain Valley judgment; phase II.	68	Partial payment made for this claim.
745	Fountain Valley judgment; phase I.	68	Partial payment made for this claim.
746	Amount withheld AB 799 audit BR 100 percent State.	46	Internal review/Audit.
747	Federally Qualified Health Center (FQHC) cost settlement adjustment recovery.	6	Balance due from the subscriber.
748	Amount withheld AB 799 rate development 100 percent Federal.	6	Balance due from the subscriber.
749	Amount withheld AB 799 rate development 100 percent State.	6	Balance due from the subscriber.
750	County hospital AB 799 provider check audit BR 100 percent State.	46	Internal review/Audit.
751	County hospital AB 799 provider check audit BR 100 percent Federal.	46	Internal review/Audit.
752	County hospital AB 799 provider check rate development 100 percent Federal.	46	Internal review/Audit.
753	County hospital AB 799 provider check rate development 100 percent State.	46	Internal review/Audit.
754	County hospital AB 799 withheld repayment agreement audit 100 percent State.	46	Internal review/Audit.
755	County hospital AB 799 withheld repayment agreement audit 100 percent Federal.	46	Internal review/Audit.
756	County hospital AB 799 provider check repayment agreement audits 100 percent State.	46	Internal review/Audit.

276/277 Transaction Code Correlation Table

Before Change		After Change	
Medi-Cal Status Codes	Description	HIPAA Claim Status Codes	Description
757	County hospital AB 799 provider check repayment agreement audits 100 percent Federal.	46	Internal review/Audit.
758	County hospital AB 799 withhold repayment rate development 100 percent State.	46	Internal review/Audit.
759	County Hospital AB 799 withhold repayment rate development 100 percent Federal.	46	Internal review/Audit.
760	County Hospital AB 799 provider check repayment rate development 100 percent State.	46	Internal review/Audit.
761	County Hospital AB 799 provider check repayment rate development 100 percent Federal.	46	Internal review/Audit.
762	Interim account repayment by provider personal check.	6	Balance due from the subscriber.
763	PTN charges.	6	Balance due from the subscriber.
764	AEVS charges.	6	Balance due from the subscriber.
765	PTN 1099 adjustments.	46	Internal review/Audit.
766	AEVS 1099 adjustments.	46	Internal review/Audit.
767	HCBS program provider refund check.	46	Internal review/Audit.
768	HCBS Program withhold.	46	Internal review/Audit.
769	HCBS Accounts Receivable payment to provider.	47	Internal review/Audit. Partial payment made.