

EOB	EOB Description	Criteria	837*	824	835	Code Type	Update Type (Added, Changed, Deleted)	Update description	Effective Date
005	This item was denied by the MCO. Contact the MCO for assistance.	This EOB will post when an item is denied by the MCO and there is no systematic denial reason in It will not post if BWC denies an item that the MCO approved for payment or that the MCO also denied.			X	Informational			
007	Payment is denied as BWC Records indicate that for date billed there is another hospital bill paid or in process from another MCO.	This EOB will post when a hospital bill is submitted that has already been submitted and paid to a different MCO.			X	Denial Code			
008	Payment is denied as BWC records indicate that for dates billed there is another hospital bill paid or in process.	This EOB will post when a hospital bill is submitted that has already been submitted and paid to the same MCO.			X	Denial Code			
009	Payment is denied as this is a duplicate line item on an inpatient bill. All charges for a revenue code must be bundled onto 1 line item for inpatient bills.	This EOB will post when the same revenue center code is billed more than once on an inpatient bill. Multiple charges for a revenue center code must be bundled on one line.			X	Denial Code			
010	Error on BWC Claim file; contact HPP SYSTEMS SUPPORT	This EOB will post if there is an undetected error on the Cambridge claim record that prevents the system from accepting an inbound 837. Contact HPP Systems Support immediately.		X		Reject Code			
020	Billed charges exceed the threshold identified by BWC for this bill type. The MCO has not indicated that it has verified that billed charges are accurate.	The billed line item provider charges exceed \$10,000 for outpatient and professional bills and \$100,000.00 for inpatient hospital bill lines. When the MCO verifies that the charges are correct, it must attach override EOB 025; otherwise the line item is denied. Due to the fact that all inpatient hospital bills are currently being reviewed by BWC, the edit for these bills will be informational only, however, the MCO should prepare to handle these as well.			X	Denial Code			
021	The interest eligibility date is before the date of service	The interest eligibility date is used to calculate line item interest. The criteria for the interest eligibility date is the date the line is eligible to be paid and this date cannot be before the date of service.			X	Denial Code			
022	The interest eligibility date is more than 90 days before BWC's receipt date.	The interest eligibility date is used to calculate line item interest. It is unlikely that interest eligibility date is more than 90 days before the BWC receipt date. If the MCO has confirmed that this is correct date then they may apply the override EOB (026).			X	Denial Code			
023	The interest eligibility date is before the MCO Received date.	The interest eligibility date is used to calculate line item interest. It is unlikely that interest eligibility date would be before the MCO receipt date. If the MCO has confirmed that this is correct date then they may apply the override EOB (026).			X	Denial Code			
025	Billed charges exceed the threshold identified by BWC for this bill type and the MCO has verified that charges are accurate.	The billed line item provider charges exceed \$10,000 for outpatient and professional bills and \$100,000.00 for inpatient hospital bill lines. When the MCO verifies that the charges are correct, it must attach override EOB 025; otherwise the line item is denied. Due to the fact that all inpatient hospital bills are currently being reviewed by BWC, the edit for these bills will be informational only, however, the MCO should prepare to handle these as well.	X		X	Override			
026	The interest eligibility date is greater than 90 days before the BWC receipt date and the MCO has verified that it is appropriate.	The interest eligibility date is used to calculate line item interest. It is unlikely that interest eligibility date is more than 90 days before the BWC receipt date. If the MCO has confirmed that this is correct date then they may apply the override EOB (026).	X		X	Override			
029	Modifier 54 added by BWC to indicate Emergency Room service does not include pre or post care	Modifier 54 will be automatically appended to the CPT© code for all professional services billed for major and minor surgical procedures performed with the Emergency Department place of service (POS 23) effective with dates of service on or after August 1, 2010.			X	Informational			
030	Payment is denied as no modifier was billed with this anesthesia procedure code	All anesthesia procedure codes require a modifier.			X	Denial Code			
031	PAY-TO PROVIDER BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data		X		Reject Code			
032	PAY-TO PROVIDER IDENTIFIERS ARE MISSING.	Neither the 11-digit BWC ID nor the NPI were submitted		X		Reject Code			
033	PAY-TO PROVIDER NPI INFORMATION BILLED IS NOT ENROLLED.	NPI information was submitted but is not in the provider file data		X		Reject Code			
034	PAY-TO PROVIDER NPI INFORMATION BILLED IS NOT UNIQUE.	The bill was submitted without a BWC ID. There is NPI information on the bill but the NPI information provided is not adequate to match the NPI to the BWC ID.		X		Reject Code			
035	SERVICING PROVIDER BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data.		X		Reject Code			
036	SERVICING PROVIDER IDENTIFIERS ARE MISSING.	Neither the 11-digit BWC ID nor the NPI were submitted.		X		Reject Code			
037	SERVICING PROVIDER NPI INFORMATION BILLED IS NOT ENROLLED.	The NPI was submitted but is not in the provider file data.		X		Reject Code			
038	SERVICING PROVIDER NPI INFORMATION BILLED IS NOT UNIQUE.	The bill was submitted without a BWC ID. There is NPI information on the bill but the NPI information provided is not adequate to cross walk the NPI to the BWC ID and must be rejected.		X		Reject Code			
039	ATTENDING PROVIDER BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
040	ATTENDING PROVIDER NPI INFORMATION BILLED IS NOT ENROLLED.	The NPI was submitted but is not in the provider file data EOB discontinued as of 2/12/2010			X	Obsolete			

041	ATTENDING PROVIDER NPI INFORMATION BILLED IS NOT UNIQUE.	The NPI was submitted but there are multiple matches in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
042	OTHER PHYSICIAN BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
043	OTHER PHYSICIAN NPI INFORMATION BILLED IS NOT ENROLLED.	The NPI was submitted but is not in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
044	OTHER PHYSICIAN NPI INFORMATION BILLED IS NOT UNIQUE.	The NPI was submitted but there are multiple matches in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
045	OPERATING PHYSICIAN PROVIDER BWC ID IS INVALID.	The 11-digit BWC ID was submitted but is not in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
046	OPERATING PHYSICIAN NPI INFORMATION IS NOT ENROLLED.	The NPI was submitted but is not in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
047	OPERATING PHYSICIAN NPI INFORMATION IS NOT UNIQUE.	The NPI was submitted but there are multiple matches in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
048	BILL PROCESSED USING BWC ID - PAY-TO PROVIDER NPI BILLED IS NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC. The NPI will not be on the 835 since it was a cross walk failure. EOB discontinued as of 2/12/2010			X	Obsolete			
049	BILL PROCESSED USING BWC ID. PAY-TO PROVIDER NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required by to use NPI in BWC billing. EOB discontinued as of 2/12/2010			X	Obsolete			
050	BILL PROCESSED USING BWC ID. PAY-TO PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID and the NPI are on the bill. They match which indicates successful enrollment and billing using NPI. The pay-to provider NPI will be included on the 835. EOB discontinued as of 2/12/2010			X	Obsolete			
051	BILL PROCESSED USING BWC ID. PAY-TO PROVIDER NPI BILL CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI. EOB discontinued as of 2/12/2010			X	Obsolete			
052	PAY-TO PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	Pay-to provider NPI information (including either Taxonomy and/or Practice Zip) are on the bill and match a single BWC provider eligibility record (11-digit BWC ID). This indicates successful enrollment and billing using NPI information. The NPI will be included along with the BWC ID on the 835. EOB discontinued as of 2/12/2010			X	Obsolete			
053	PAY-TO PROVIDER NPI/TAXONOMY BILLED, PARTIAL MATCH - TAXONOMY NOT ENROLLED.	NPI information (including Taxonomy) are on the bill. The NPI is used to obtain a single match (successful crosswalk) but the Taxonomy is not in the provider file data. The NPI will be included along with the BWC ID on the 835. EOB discontinued as of 2/12/2010			X	Obsolete			
054	BILL PROCESSED USING BWC ID. SERVICING PROVIDER NPI BILLED NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC. The NPI will not be on the 835 since it was a cross walk failure. EOB discontinued as of 2/12/2010			X	Obsolete			
055	BILL PROCESSED USING BWC ID. SERVICING PROVIDER NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required by to use NPI in BWC billing. EOB discontinued as of 2/12/2010			X	Obsolete			
056	BILL PROCESSED USING BWC ID. SERVICING PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID and the NPI are on the bill. They match which indicates successful enrollment and billing using NPI. The servicing provider NPI is included along with the BWC ID on the 835. EOB discontinued as of 2/12/2010			X	Obsolete			
057	BILL PROCESSED USING BWC ID. SERVICING PROVIDER NPI BILLED CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI. EOB discontinued as of 2/12/2010			X	Obsolete			
058	SERVICING PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	Servicing provider NPI information (including either Taxonomy and/or Practice Zip) are on the bill and match a single BWC provider eligibility record (11-digit BWC ID). This indicates successful enrollment and billing using NPI information. The NPI will be included on the 835. The BWC ID will be included if submitted on the bill. EOB discontinued as of 2/12/2010			X	Obsolete			
059	SERVICING PROVIDER NPI/TAXONOMY BILLED, PARTIAL MATCH. TAXONOMY NOT ENROLLED	The NPI is used to obtain a single match (successful crosswalk) but the Taxonomy is not in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
060	BILL PROCESSED USING BWC ID. ATTENDING PHYSICIAN NPI BILLED IS NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC. EOB discontinued as of 2/12/2010			X	Obsolete			
061	BILL PROCESSED USING BWC ID. ATTENDING PHYSICIAN NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required by to use NPI in BWC billing. EOB discontinued as of 2/12/2010			X	Obsolete			
062	BILL PROCESSED USING BWC ID. ATTENDING PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID is on the bill. The NPI information on the bill matches the NPI information in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			

063	BILL PROCESSED USING BWC ID. ATTENDING PROVIDER NPI BILLED CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI. EOB discontinued as of 2/12/2010			X	Obsolete			
064	ATTENDING PROVIDER NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The NPI information on the bill matches the NPI information in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
065	BILL PROCESSED USING BWC ID. OTHER PHYSICIAN #1 NPI BILLED NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC. EOB discontinued as of 2/12/2010			X	Obsolete			
066	BILL PROCESSED USING BWC ID. OTHER PHYSICIAN #1 NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required by to use NPI in BWC billing. EOB discontinued as of 2/12/2010			X	Obsolete			
067	BILL PROCESSED USING BWC ID. OTHER PHYSICIAN #1 NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID is on the bill. The NPI information on the bill matches the NPI information in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
068	BILL PROCESSED USING BWC ID. OTHER PHYSICIAN #1 NPI BILLED CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI. EOB discontinued as of 2/12/2010			X	Obsolete			
069	OTHER PHYSICIAN #1 NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The NPI information on the bill matches the NPI information in the provider file data. EOB discontinued as of 2/12/2010			X	Obsolete			
070	Multiple servicing providers were sent on one bill.	A bill was submitted indicating more than one servicing provider on one bill.		X		Reject Code			
072	MCO received date is invalid.	The date received by the MCO is invalid		X		Reject Code			
075	MCO priced total is not the sum of MCO priced lines.	The total amount priced by the MCO does not equal the total of priced lines.		X		Reject Code			
077	Values in this field exceed the valid range.	The values in this field have exceeded the valid range		X		Reject Code			
079	Bill was submitted with over 99 detail lines.	BWC does not accept bills with more than 99 lines or line numbers over 99		X		Reject Code			
080	This bill meets criteria for BWC's post-acute care transfer policy. The DRG payment rate is overridden by PACT payment rate. See Provider Billing & Reimbursement Manual for policy details.	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill is reimbursed using Medicare's post-acute care transfer per diem methodology			X	Informational			
081	Bill meets criteria for BWC's special post-acute care transfer policy. The DRG payment rate is overridden by the special PACT payment rate. See Provider Billing & Reimbursement Manual for details.	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill is reimbursed using Medicare's special post-acute care transfer per diem methodology			x	Informational			
085	Payment is denied as the admission history and physical is missing. Please fax documentation to MCO & resubmit bill.	Attached by BWC if admission history and physical is required to determine whether an inpatient hospital bill can be paid and has not been submitted by the provider.			X	Denial Code			
086	Payment is denied as the emergency department report is missing. Please fax documentation to the MCO and resubmit bill.	Attached by BWC if emergency department report is required to determine whether an inpatient hospital bill can be paid and has not been submitted by the provider.			X	Denial Code			
087	Payment is denied as the operative report is missing. Please fax documentation to the MCO and resubmit bill.	Attached by BWC if the op report is required to determine whether an inpatient hospital bill can be paid and has not been submitted by the provider.			X	Denial Code			
088	Payment is denied as the progress notes and/or the discharge summary are missing. Please fax documentation to the MCO and resubmit bill.	Attached by BWC if progress notes or a discharge summary are required to determine whether an inpatient hospital bill can be paid and has not been submitted by the provider.			X	Denial Code			
089	Corrected payment is being made on an inpatient hospital bill.	Attached by BWC if an inpatient hospital bill has been reconsidered and is being paid at a corrected rate.			X	Informational			
090	Payment is denied as, except for servicing provider, this is a duplicate of a previously paid service.	Exact duplicate except: servicing provider. BWC no longer uses this EOB.				Obsolete	Changed	Change to document that this EOB is obsolete.	10/10/2003
096	Payment is denied - duplicate outpatient bill processed under OPPS.	This denial applies to outpatient bills with dates of service 1/1/2011. If the bill is from the same provider and for the same claim number, service type (therapy or non-therapy) and service date range as a previously approved outpatient hospital bill and includes changes to services, units or charges, the MCO should request an adjustment to correct the original bill. If the bill is an exact duplicate of a previously-paid bill, the MCO should use this EOB to deny the bill as a duplicate.	X		X	Denial Code	Changed	Change to document that MCOs can send this EOB on the 837. Clarified Criteria.	11/6/2013
097	Payment is denied as, except for billed charges and units of service, this is a duplicate of a previously paid service.	Exact duplicate except: billed amount and/or units. If a change is made in the amount or units billed by the provider, the MCO must request an adjustment of the original bill. BWC No longer uses this EOB.				Obsolete	Changed	Change to document that this EOB is obsolete.	10/10/2003
098	Payment denied - different provider, same MCO, same service, same injured worker.	This EOB will be effective in early 2011. This EOB will apply to professional bills where the same services have been billed by two different providers for the same claim number on the same date. If the MCO has verified that the services are not duplicates, it can attach override EOB 745 to authorize payment of the distinct services.	X		X	Denial Code			

099	Payment is denied as BWC's records indicate that this is an exact duplicate charge for a service that has already been paid or is in process.	Exact duplicate of a bill submitted by the same MCO.			X	Denial Code			
100	Payment is denied as this is an exact duplicate except MCO, billed amount, units of service.	This EOB will be generated when a bill meets BWC's criteria for an exact duplicate, except for units and billed amount. If a change is made in the billed amount or in the units billed by the provider, the MCO must request an adjustment of the original bill. BWC No longer uses this EOB.				Obsolete	Changed	Change to document that this EOB is obsolete.	10/10/2003
101	Payment is denied as this bill is an exact duplicate of another previously paid bill or another bill being processed.	Exact duplicate of a bill submitted by a different MCO.			X	Denial Code			
104	Payment is denied as the office/hospital visit falls within the post-surgical follow-up period.	This bill contains an office visit, hospital or nursing home visit from the same provider and the date of service is one day prior to the surgery or falls within the follow-up period of a previously paid bill with surgical procedures.	X		X	Obsolete	Changed	MCOs can begin using the appropriate clinical editing EOBs (407-412) immediately, but must begin using 407-412 no later than 1/1/2014.	1/1/2014
105	Payment is denied as the procedure code conflicts with the diagnosis code on the invoice.	The procedure billed is not appropriate for treatment of the condition indicated on the bill.	X		X	Denial Code			
107	Payment is denied as BWC does not reimburse for missed appointments.	This EOB may be used if documentation indicates that a service was scheduled, but the injured worker did not keep the appointment.	X		X	Denial Code			
110	Payment is denied as the combination of modifiers is invalid.	BWC has designated all valid modifiers as Information, Role, or Location modifiers. If more than one information or role modifier (for example, 80 & 81) is billed on a line, the bill will be rejected with this EOB.		X		Reject Code			
113	This procedure exceeds the BWC limit for procedures (CPT 10000-69999) per date of service.	Effective until 12/31/2011 - This was a denial EOB indicating that more than 5 procedures (10000-69999) had been billed for one date of service. This EOB should not be used on bills with dates of service after 12/31/2011.	X		X	Obsolete	Changed	Clarified criteria to indicate that this should not be used with current dates of service and changed to obsolete.	12/31/2011
115	Payment is denied as the units of service for this room rate conflict with the covered dates of hospitalization.	The units of service billed with accommodation codes on one bill are greater than the number of days covered in this bill.		X		Reject Code			
116	Payment is denied as the line item date of service is missing or invalid.	The line item date of service is missing on an outpatient hospital bill.		X		Reject Code			
117	Payment is denied as the modifier is invalid.	The modifier billed is not valid for BWC.		X		Reject Code			
118	Payment is denied because the modifier billed was not valid on the date of service.	The modifier was not valid on the date of service.			X	Denial Code			
119	Payment is denied because the servicing provider is not eligible to use the modifier billed.	The servicing provider cannot use the modifier billed.	X			Denial Code			
120	Invalid UB-92 bill type.	The bill type submitted is invalid according to BWC guidelines. Please refer to BWC's BRM for correct bill types.			X	Denial Code			
121	Payment is denied as pay-to and servicing provider information is missing.	This EOB is generated when no provider information is included on the 837.		X		Reject Code			
122	Payment is denied as the line item date of service is not within the covered dates.	Line item date of service is not within the covered dates on an outpatient bill.		X		Reject Code			
123	Payment is denied as a date field on the invoice contained an invalid year, month, or day.	This EOB is generated when any date field contains invalid information.		X		Reject Code			
124	Payment is denied as the beginning or ending service date is missing or invalid.	The beginning covered date is after the ending covered date on a hospital bill.		X		Reject Code			
125	Payment is denied as the bill/adjustment was not received within the timeframe required by statute.	For initial bills with dates of service before 7/29/2011 - The MCO received date was not within two years of the date of service. For initial bills with dates of service on/after 7/29/2011 - The MCO received date was not within one year of the date of service. For adjustments with date of service on/after 9/12/2011 - The adjustment date is not within 1 year 7 days of the original BWC adjudication date.	X		X	Denial Code			
126	Service "from" date is after service "to" date.	The "from" service date is greater than the "to" service date.	X			Denial Code			
128	Payment is denied as the admitting diagnosis is missing.	On an inpatient hospital bill, the admitting diagnosis is missing.		X		Reject Code			
130	(This EOB has been removed.) Payment is denied as the condition codes listed on the bill are invalid.	On a hospital bill, the condition code is invalid.				Obsolete			
131	Payment is denied as this bill contains duplicate line item numbers.	Line item numbers on one bill are duplicates. For example, there are two line items, but both are listed as line item 1.		X		Reject Code			
132	Payment is denied as provider total charge is missing.	The bill will be rejected if the provider total charge is missing.		X		Reject Code			
133	Payment is denied as the provider total doesn't equal the line item totals.	The bill will be rejected if the provider total doesn't equal the total of all of the line items.		X		Reject Code			
134	Payment is denied as the MCO charge is missing.	The bill will be rejected if the sum of the MCO's line item charges does not equal the MCO's total charge.		X		Reject Code			

136	(This EOB has been removed.) The occurrence code is invalid.	The occurrence code on a hospital bill is invalid.		X		Obsolete	Changed	Code type updated to reflect criteria. This code is obsolete.	10/10/2003
137	(This EOB has been removed.) The occurrence dates are missing.	The occurrence dates are missing.				Obsolete			
140	(This EOB has been removed.) The value code is invalid.	The value code on a hospital bill is invalid.				Obsolete			
145	Payment is denied as the place of service is invalid.	The billed place of service on a non-facility bill is not a HCFA standard value.		X		Reject Code			
147	Payment is denied as the daily room rate was omitted.	The daily room rate was omitted when billing an accommodation revenue center code on an inpatient hospital bill.		X		Obsolete	Changed	Updated status to reflect that this will go away once all MCOs have migrated to 5010.	3/1/2014
148	Payment is denied as the revenue code is missing.	There is no revenue center code on a hospital bill line.		X		Reject Code			
149	Payment is denied as the first and last dates of service cannot coincide for inpatient hospitalizations.	On an inpatient hospital bill, the first and last dates covered are equal.		X		Reject Code			
158	Payment is denied as the accommodation billed total is not equal to the daily rate times the number of days.	On an inpatient hospital bill, the total billed for an accommodation code must equal the daily rate times the number of days.		X		Obsolete	Changed	Updated status to reflect that this will go away once all MCOs have migrated to 5010.	3/1/2014
159	Payment is denied as the EOB submitted by MCO is not on file.	A bill contains an EOB that is not in BWC's data base. MCOs must use the EOBs defined by BWC. BWC can easily add EOBs to its list as MCOs identify new requirements.		X		Reject Code			
161	A denial EOB code was submitted, but MCO's priced amount is not zero.	The MCO submitted a bill containing a denial EOB code at the line-item or header level but the MCO's priced amount is not \$0.00.		X		Reject Code			
162	Bill contains a \$0.00 as MCO-priced amount, but no denial EOB was submitted.	The MCO submitted a bill containing a line-item or header level priced amount of \$0.00 but did not submit a denial EOB to explain the price.		X		Reject Code			
165	Payment is denied as the modifier is invalid for anesthesia services.	A modifier was used that is not valid for anesthesia. Refer to pages 4-5 & 4-6 in BWC's Billing and Reimbursement manual.	X			Denial Code			
167	Payment is denied as the patient status is invalid.	The patient status code on an inpatient hospital bill is invalid.		X		Reject Code			
169	Payment is denied as this modifier is not valid with the procedure code billed.	The modifier billed is not valid with the procedure code.	X		X	Denial Code			
171	Payment denied as the line item dates of service do not match the header date of service range on an outpatient bill.	Header dates must equal earliest and latest line dates on an outpatient hospital bill.		X		Reject Code	Added	New EOB to prevent pricing errors when header dates are outside an OPPS rate period.	1/1/2014
172	Payment is denied as the procedure code is missing.	There is no HCPCS Level I, II or III code on a non-facility bill.		X		Reject Code			
173	The admission date and the service date conflict.	BWC is turning off this EOB. It will no longer set. The admission date on an inpatient hospital bill is after the first covered date.				Obsolete			
174	Payment is denied as the admission and/or discharge hour is missing.	The admission or discharge hour on an inpatient hospital bill is missing.		X		Reject Code			
175	Payment is denied as the admission source is missing or invalid.	Admission source on an inpatient hospital bill is missing or invalid.		X		Reject Code			
181	Payment is denied as ICD-9 "E" diagnosis codes are not allowed on non-facility bills.	Effective 1/1/2011, MCOs can submit E-codes on non-facility 837s as long as they are billed in accordance with correct coding standards. This change is being made to ensure that BWC can capture E-codes related to a claim. It is never appropriate for the E-code to be the primary code, but it may be one of the ancillary codes on a professional bill.				Obsolete			1/1/2011
183	Payment is denied as the units of service are missing or invalid.	No units of service are included on a line item.		X		Reject Code			
184	Payment is denied as the line item charge is missing or invalid.	A line item charge is missing or non-numeric.		X		Reject Code			
185	Payment is denied as the admission date is missing.	Admission date is missing on an inpatient hospital bill.		X		Reject Code			
187	Payment is denied as the EOB code is not on file.	The MCO submitted an EOB that is not on file at BWC.		X		Reject Code			
191	Payment is denied as the admission type is invalid.	The admission type is invalid on an inpatient hospital bill.		X		Reject Code			
192	Payment is denied as ICD-9 "E" codes are not acceptable for the principal diagnosis.	ICD-9 "E" codes will be rejected if billed as the principal diagnosis on a hospital bill.		X		Reject Code			
193	Payment is denied as the date of the principal procedure is not within the covered dates.	The date the principal procedure was performed is not within the covered dates indicated on a hospital bill.		X		Reject Code			
195	DRG changed as a result of coding modification	Following BWC review the diagnosis and/or procedure coding was changed on the bill. This EOB is used to notify the MCO and providers that the coding changes will affect the DRG assignment.			X	Informational			
196	Payment is denied as ICD-9 procedure code is not valid.	The ICD-9 procedure on a hospital bill is invalid.		X		Reject Code			
198	(This EOB has been removed.) Payment is denied as the date of surgery is missing.	Date of surgery is missing from the UB-92 block 80				Obsolete			
199	(This EOB has been removed.) ICD-9 procedure code is missing.	ICD-9 procedure code is missing from the UB-92 block 80				Obsolete			

200	Payment is denied as only one diagnosis code may be billed per line.	BWC does not accept more than one diagnosis code per line item on non-facility bills (HCFA-1500, C-19). A bill containing this error cannot be transmitted to BWC electronically so this is one of the few errors that can be rejected by an MCO without submission to BWC. The MCO should use this EOB in conjunction with the MPRG guidelines for rejecting bills.				MCO rejection			
201	The sequence of the procedure codes submitted on the inpatient hospital bill has been reordered by BWC to match medical documentation and correct coding standards	Following a BWC review of an inpatient hospital bill the sequence of the procedure codes may be changed to match the medical documentation and correct coding standards.			X	Informational			
202	BWC has added and/or deleted ICD-9 diagnosis codes to the inpatient hospital bill	Following a BWC review of an inpatient hospital bill, ICD-9 diagnosis codes have been added and/or deleted from the bill to match the medical documentation and coding standards.			X	Informational			
203	BWC has added and/or deleted procedure codes to the inpatient hospital bill	Following a BWC review of an inpatient hospital bill, procedure codes have been added and/or deleted from the bill to match the medical documentation and coding standards.			X	Informational			
204	The covered days on an interim hospital bill type 112 or 113 is less than 30.	BWC expects covered days for interim hospital bills, type 112 and 113, to be equal or greater than 30 days.			X	Denial Code			
205	HOSPITAL SUBMITTED BILL FOR REHAB/PSYCH SERVICES USING ACUTE CARE PROVIDER NUMBER. RESUBMIT WITH CORRECT NUMBER. IF CORRECT NUMBER IS NOT KNOWN CONTACT PROVIDER RELATIONS AT 1-800-OHIOBWC	Applied when a BWC review looks at the psych/rehab serviced billed by a hospital using an Acute Care provider number and determines that these services should have been billed by a hospital using a psych or rehab provider number.			X	Denial Code			
206	LATE CHARGES BILL IS DENIED. SUBMIT ON HOSPITAL BILL TYPE 115 ALONG WITH A REQUEST FOR ADJUSTMENT TO THE MCO	Applied when late charges are not submitted on a bill type 115, the bill/line will be denied.			X	Denial Code			
207	The interim hospital bill, type 113, is not eligible for additional reimbursement	BWC has reviewed the interim hospital bill, type 113 and determined that it is not eligible for additional reimbursement.			X	Denial Code			
208	Requested medical documentation has not been received by BWC.	BWC has requested medical documentation for bill validation and has not received it in a timely manner.			X	Denial Code			
209	Inpatient hospital readmission is not eligible for additional reimbursement.	The bill has been reviewed and determined that the readmission is not eligible for additional reimbursement. The readmission is covered under the original admission.			X	Denial Code			
210	The claim is part of the Medical-Only Program. The employer is responsible for all bills until the \$1,000/5,000/15,000 limit has been met.	Employers who participate in the BWC Medical-Only Program choose to directly pay for medical services related to a compensable work related injury. The employer may pay for all medical treatment in their employee's medical-only claim up to a specific dollar limit (\$1,000, \$5,000, or \$15,000 depending on the date of injury of the claim and the date the employer enrolled in the program). During the period of time that the employer is responsible for bills, providers should seek reimbursement from the employer. The employer may choose to remove a claim from the program at any time, but is responsible for the amount (up to \$1,000, \$5,000, or \$15,000) as long as the claim is part of the Medical-Only Program. \$1,000 Medical-Only Program (H.B. 107 1993): DOI 7/1/1995 through DOI 6/29/06. \$5,000 Medical-Only Program (S.B. 7 2006): DOI 6/30/06 through 9/9/07. \$15,000 Medical-Only Program (H.B. 100 2007): DOI 9/10/07 and after.	X		X	Denial Code			
211	Payment denied - Medical benefits suspended because the injured worker failed to appear for an ADR/IME.	Medical benefits have been suspended because the injured worker failed to appear at an independent medical exam pursuant to a dispute. This EOB can be overridden by an MCO with EOB 744 in the event that treatment is billed that is excepted from the suspension (i.e. emergency or life-sustaining treatment).	X		X	Denial Code			1/1/2011
212	The sequence of the ICD-9 codes on the bill has been changed to match the medical documentation.	BWC has reviewed the medical documentation associated with this inpatient hospitalization stay. The ICD-9 diagnosis code sequence has been changed to match the documentation.			X	Informational			
213	The MCO's priced amount is different then the provider's billed amount on the hospital bill because they have a contractual arrangement with the provider.	BWC expects the MCO priced amount to be equal to the provider billed amount on inpatient hospital bills except when the MCO has an agreement with the provider to pay at a different rate. If a contract is in place, the MCO can price the bill according to the contract terms and must attach this EOB. This requirement has been in effect for inpatient bills since 2007. The requirement goes into effect for outpatient bills on 1/1/2011 with the OPPS implementation. Failure to follow this requirement will result in incorrect pricing.	X		X	Informational			
214	The principal procedure on the inpatient hospital bill appears to be unrelated to the claim.	Applied to an inpatient hospital bill when the principal procedure appears to be unrelated to the treatment of the allowed conditions in the injured worker's claim.	X		X	Denial Code			
215	The second procedure appears to be unrelated to the claim.	Applied to an inpatient hospital bill when the second procedure appears to be unrelated to the treatment of the allowed conditions in the injured worker's claim.	X		X	Informational			
216	The third procedure appears to be unrelated to the claim	Applied to an inpatient hospital bill when the third procedure appears to be unrelated to the treatment of the allowed conditions in the injured worker's claim.	X		X	Informational			

217	The fourth procedure appears to be unrelated to the claim	Applied to an inpatient hospital bill when the fourth procedure appears to be unrelated to the treatment of the allowed conditions in the injured worker's claim.	X		X	Informational			
218	The fifth procedure appears to be unrelated to the claim	Applied to an inpatient hospital bill when the fifth procedure appears to be unrelated to the treatment of the allowed conditions in the injured worker's claim.	X		X	Informational			
219	The sixth procedure appears to be unrelated to the claim	Applied to an inpatient hospital bill when the sixth procedure appears to be unrelated to the treatment of the allowed conditions in the injured worker's claim.	X		X	Informational			
222	The principal diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the principal Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007. (Use 276 instead.)				Denial Code			
223	The second diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the second Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
224	The third diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the third Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
225	The fourth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the fourth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
226	The fifth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the fifth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
227	The sixth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the sixth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
228	The seventh diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the seventh Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
229	The eighth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the eighth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
230	The ninth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the ninth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
231	The tenth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the tenth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
232	The eleventh diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the eleventh Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
233	The twelfth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the twelfth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
234	The thirteenth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the thirteenth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
235	The fourteenth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the fourteenth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
236	The fifteenth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the fifteenth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
237	The sixteenth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the sixteenth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
238	The seventeenth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the seventeenth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
239	The eighteenth diagnosis code appears to be unrelated to the claim	Applied to an inpatient hospital bill when the eighteenth Diagnosis code appears to be unrelated to the Injured worker's claim. Obsolete as of 3/31/2007.				Informational			
244	Payment is denied as the date of service is prior to the HPP implementation date. This bill should be submitted directly to BWC.	The date of service is prior to 3/1/97 if this is an "alpha" claim. Otherwise, the date of service is prior to the MCO's "beta" or "gamma" effective date. If the claim is for an occupational disease, payment must be coordinated with BWC.	X		X	Denial Code			
245	Payment is denied as claim number has changed. Please re-bill using current claim number.	The claim number billed has been combined into another claim. Two claim records exist for the same incident and the number billed is not associated with the most current information. If the MCO has no record of a second claim number, it should contact the BWC Customer Service Team.	X		X	Denial Code			
246	CO-MORBID/COMPLICATION DIAGNOSIS CODE(S) DELETED AS NOT SUPPORTED BY MEDICAL DOCUMENTATION RECEIVED BY BWC, RESULTING IN DRG CHANGE	Following a BWC review of an inpatient hospital bill, CO-MORBID/COMPLICATION DIAGNOSIS CODE(S) have been deleted from the bill to match the medical documentation and coding standards.			X	Informational			
247	CO-MORBID/COMPLICATION DIAGNOSIS CODE(S) ADDED AS SUPPORTED BY MEDICAL DOCUMENTATION RECEIVED BY BWC, RESULTING IN DRG CHANGE	Following a BWC review of an inpatient hospital bill, CO-MORBID/COMPLICATION DIAGNOSIS CODE(S) have been added to the bill to match the medical documentation and coding standards.			X	Informational			
250	Payment is denied as the claim number is not valid.	The claim number billed does not exist in the BWC claim data base.		X		Reject Code			

251	Payment is denied as this claim has been settled. This bill is the injured worker's responsibility.	This EOB should be used to deny all bills where the claim is in a Settled Medical status, or in a Settled Both status (where both Medical and Indemnity are settled) where the date of service is on or after the settlement date.	X		X	Denial Code			
253	Payment is denied as self-insuring employers pay their own bills directly.	The claim number billed indicates that the employer is self-insured. The bill must be submitted to the employer.		X		Reject Code			
254	BWC's jurisdiction over medical-only claims ends six years after the date of injury. This bill is the injured worker's responsibility.	For medical-only claims with dates of injury prior to 10/20/93, no payments can be made for dates of service more than 6 years past the date of injury.	X		X	Denial Code			
256	This claim has been disallowed. The injured worker is responsible for bills.	BWC will not pay for any services in a claim that is disallowed. The claim status code on the 148 transaction is "DA" if the claim is disallowed.	X		X	Denial Code			
257	Payment is denied as this claim has reached the statute of limitations. The claimant is responsible for bills.	Statute of limitations has been reached. Claimant is responsible for bills. Further questions should be directed to the Customer Service Team.			X	Denial Code			
262	Payment is denied as the date of service is after the injured worker's death date.	Services were billed for a date of service after the injured worker's date of death.	X		X	Denial Code			
265	Payment is denied as because the claim is inactive. Please refer to the Billing and Reimbursement Manual or contact the MCO for additional information.	If services are greater than 24 months from the Last Paid Date of Service and the claim is in an Inactive status, BWC will systematically deny the bill. MCOs are to follow BWC guidelines, policies and procedures regarding handling requests for treatment that fall under Claim Reactivation Guidelines. (Effective date applies to description only; changed from 13 months to 24 months.)	X		X	Denial Code			
267	MCO cannot make a payment decision at this time as a determination of relatedness has not yet been made.	MCOs should use this EOB to prevent payment until a reactivation review is completed. This EOB cannot be used for services that do not require prior authorization unless a C9 has triggered a review. Example: Claim is inactive and MCO receives a bill for an office visit along with a C9 for an MRI. The C9 requires a review so it is appropriate to delay payment of the office visit using this EOB. If reactivation is approved, then the bill can be adjusted or resubmitted.	X		X	Denial Code			
269	Payment is denied as BWC allows only one date of service per line item.	On non-facility bills, BWC allows only one date of service per line item.		X		Reject Code			
270	Payment is denied as this diagnosis has been formally disallowed and there is no proof of relationship to the allowed injury.	BWC cannot reimburse services rendered for a condition that has been formally disallowed. The only exceptions are: 1) if the condition can be considered pre-existing and has been aggravated by the compensable injury or treatment of the injury, or 2) if the condition is the result of treatment of the injury. In these cases, BWC will reimburse stabilization of a condition. The MCO must request an adjustment of the denied bill in order for the charges to be reimbursed.	X		X	Denial Code			
276	Payment is denied as the billed diagnosis is not allowed in this claim.	The condition treated is not allowed in the claim. It is appropriate to use this code while a condition is pending allowance. (The statuses of the ICD-9 codes associated with a claim are included in the data sent from BWC to the MCO in the 148 transaction set.) It is also appropriate for use when the condition is not associated with the claim and there is no relationship between the treated condition and the compensable injury. If a condition is not allowed, but the MCO believes treatment should be covered on a limited basis, an override EOB must be used when the MCO submits the bill to BWC. (See Override EOBs.)	X		X	Denial Code			
279	Payment is denied as the disc level treated has not been allowed in this claim.	This denial code must be used if a review of medical documentation indicates that a disc level was treated that is not allowed in the claim and there is no relationship to the allowed injury.	X		X	Denial Code			
281	Payment is denied as the date of service/admission is prior to the date of injury and this is an OD claim.	The date of admission or date of service on the bill is prior to the date of injury of an OD claim. This EOB can be overridden with EOB 783.	X		X	Denial Code			
283	Payment is denied as the date of service/admission is prior to the date of injury for a non-OD claim.	The date of admission or date of service on the bill is prior to the date of injury of an OD claim. This EOB cannot be overridden.	X		X	Denial Code			
284	Payment is denied as treatment in this claim is subject to joint BWC and MCO review.	Under extraordinary circumstances, BWC may identify a claim where special handling of medical payments is required. In such cases, BWC will suspend payment in the claim and the MCO will need to confer with the BWC contact in this claim before authorizing payment. This EOB can be overridden with override EOB 743.			X	Denial Code			1/1/2011
291	As of April 1, 2014 MCOs and BWC will no longer accept the C-19 form for the services you have billed. Please begin to use the new CMS-1500 (02/12) form at your earliest opportunity.	The recommendation has been made to discontinue the C-19 and create a form that will be used by certain workers'-comp specific provider types or to bill specific procedure codes. Once the provider and code types are identified, this document will be updated. This EOB is being published so that MCOs can add the EOB to their systems while adding other new EOBs to their systems.	X		X	Informational	Added		1/1/2014
293	Payment is denied as BWC's jurisdiction over medical-only claims with DOI on or after 10/20/93 ends six years after the last payment date. This bill is the injured worker's responsibility.	This denial code applies to medical-only claims with a date of injury after 10/20/93.	X		X	Denial Code			

294	Payment is denied as BWC's jurisdiction over lost-time claims ends ten years after the last payment date. This bill is the injured worker's responsibility.	The last compensation or medical payment was made over 10 years prior to the date of service and this is a lost-time claim.	X		X	Denial Code			
295	Payment is denied as this procedure is not covered by BWC on outpatient hospital bills.	The billed procedure code will not be reimbursed by BWC on an outpatient hospital bill; it cannot be overridden or adjusted to pay. BWC has created a separate EOB for outpatient hospital bills as the systematic criteria for coverage are different than on professional or ASC bills.	X		X	Denial Code			
296	Payment is denied as the servicing provider number billed belongs to a group practice.	The servicing provider number billed has a provider type of 12. The servicing provider number must always be that of the individual rendering medical services.		X		Reject Code			
301	This bill is paid as a BWC outlier	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill meets the criteria of a BWC outlier.			X	Informational			
302	This bill is paid as a BWC DRG	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill meets the criteria of a BWC DRG.			X	Informational			
303	This bill was priced using a non-DRG method	Informs the MCO and hospital of the pricing methodology used to pay the bill. This indicates that the bill could not be eligible for DRG pricing and was priced using a non-DRG method.			X	Informational			
315	Payment is denied as the servicing provider number is invalid.	The servicing provider number is not found on BWC's data base. The provider number is the 11-digit number assigned by BWC. BWC is unable to price bills without this information.		X		Reject Code			
323	Payment is denied as the diagnosis billed does not match the diagnosis code listed in the accompanying reports.	Medical documentation submitted indicates that the diagnosis treated is different than the one that was billed.	X		X	Denial Code			
326	Payment is denied as this procedure was not valid on the date of service.	The billed procedure code was not valid on the date of service. This EOB is generated when a new code is billed before its effective date and when an expired code is billed after its expiration date.	X		X	Denial Code			
327	Payment is denied as the medical documentation provided is not adequate to justify reimbursement.	Medical documentation submitted doesn't justify payment for services rendered.	X			Denial Code			
329	Payment is denied as BWC does not reimburse for experimental or investigational procedures.	Services provided that are not covered by BWC. Refer to page 2-31 in BWC's Billing and Reimbursement Manual.	X		X	Denial Code			
330	Payment is denied as the type of service or procedure does not appear to be related to the allowed compensable condition.	The procedure code billed is not related to the allowed diagnosis in the claim.	X		X	Denial Code			
331	Payment is denied as the claim is not recognized for the diagnosis code billed. Medical documentation must be submitted to the BWC Customer Service Team if the treatment is related to the industrial injury.	Services are billed for a condition that is not allowed in the claim. The claim allowance may need to be amended if treatment is for the industrial injury. This may also be a situation where Miller guidelines apply and EOB 776 must be used.	X			Denial Code			
332	Payment is denied as the servicing provider is not eligible for reimbursement.	The service billed is not within the provider's scope of service.	X		X	Denial Code			
340	Payment is denied as the condition billed is allowed in a different claim.	Records indicate that the condition billed is allowed in another existing claim. Rebill with the correct claim number.	X		X	Denial Code			
341	Payment is denied as a hospital cannot be the servicing or payee provider on a non-facility bill.	Hospital providers cannot bill on the non-facility form.		X		Reject Code			
343	Payment is denied. ICD code is expired for this date of service. Future submission must contain the correct code that reflects the condition being treated.	This diagnosis code is on the list of invalid diagnosis codes maintained by BWC and is not one of the diagnosis codes allowed in the claim. Refer to the Coding and Reimbursement Standards chapter of the BWC MCO Policy Overview for more information.	X		X	Denial Code			
344	Payment is denied as the ICD-9 code is missing or invalid.	The ICD-9 diagnosis code does not exist in BWC's ICD-9 code data base or there is no diagnosis on the invoice.		X		Reject Code			
345	Payment is denied following reconsideration with documentation submitted by your office.	Medical documentation has been reviewed by medical staff and the service was found ineligible for reimbursement.	X		X	Denial Code			
346	Payment is denied as the billing provider is not documented as the injured worker's vendor of choice for the DME item billed.	This EOB should be used to deny payments if a vendor continues to provide and bill for DME items after the injured worker has selected another vendor.	X		X	Denial Code			
347	Payment is denied as medical documentation submitted does not include a description of all the components the item provided.	Medical documentation has been reviewed by medical staff and found to be incomplete.	X		X	Denial Code			
348	Payment is denied as documentation does not justify use of a non-specific procedure code.	Documentation submitted indicates a more specific CPT code or a HCPCS code may be more appropriate.	X			Denial Code			
349	Payment is denied as medical documentation doesn't clearly describe the service.	Documentation submitted is not specific in describing the service that was provided.	X			Denial Code			
351	Payment is denied as the procedure code billed indicates treatment of a condition not allowed in the claim.	Services billed indicate that treatment was for a non-allowed condition; however, the diagnosis billed was one of the allowed conditions. If Miller guidelines apply in this case, the bill should be resubmitted with the diagnosis treated and override EOB 776.	X			Denial Code			
352	Payment is denied as the report submitted does not sufficiently describe the service or procedure billed under the unlisted procedure code.	Medical documentation does not adequately show the nature of the unlisted code billed.	X		X	Denial Code			
353	Payment is denied as prior authorization is required for this service.	Service billed requires prior authorization according to MCO medical policy.	X		X	Denial Code			

356	Payment is denied as treatment or services billed do not correspond to treatment or services described in medical documentation.	Medical documentation submitted indicates services rendered are different than services billed.	X		X	Denial Code			
357	Payment is denied as this physical medicine modality exceeds the maximum allowed without prior authorization	Modalities billed have exceeded amount allowed by MCO guidelines.	X			Denial Code			
358	Payment is denied as this procedure exceeds the maximum number of surgical procedures that can be reimbursed to an Ambulatory Surgical Center for this date of service.	ASCs are reimbursed for up to 2 surgical procedures for dates of service prior to 1/1/2002 and up to 4 surgical procedures for dates of service on or after 1/1/2002. No longer used as of 4/1/2009	X		X	Obsolete			
360	Payment is denied as the report submitted does not indicate that significant, separately identifiable E/M services were provided.	Medical report does not adequately show what significant E/M services were provided.	X			Denial Code			
361	Payment is denied as the procedure code is invalid.	The level I, II, or III HCPCS code billed does not exist in BWC's data base.		X		Reject Code			
369	Payment is denied as the revenue center code is invalid for the date billed.	Revenue center code is not valid for the dates of service billed.	X		X	Denial Code			
370	Payment is denied as the revenue center code is invalid.	The revenue center code does not exist in BWC's data base.		X		Reject Code			
376	Payment is being made for the treating condition according to Miller criteria.	The MCO should attach this EOB to authorize payment for a condition that may or may not be recognized in the claim but that is eligible for treatment according to the Miller criteria. This is not an override EOB, so if the treating condition is not recognized in the claim, the MCO must also attach override EOB 776 to ensure payment.	X			Informational			
379	Payment is denied as this procedure or service is not eligible for reimbursement to an ambulatory surgical center.	Effective until 03/31/2009 - There is no ASC group associated with this procedure code. Effective 4/1/2009 - The is considered a non-covered service for an ASC setting.	X		X	Denial Code			
380	Payment is denied as the anesthesia modifier is not appropriate to be billed with this procedure code.	An anesthesia modifier cannot be used with the procedure code billed.	X			Denial Code			
382	Payment is denied as the revenue center code requires a HCPCS code and the HCPCS code is missing.	This denial code applies only to outpatient hospital bills.	X		X	Denial Code			
384	Procedure was reimbursed up to the maximum number allowed per day.	This EOB will be generated when the units of service billed exceed the maximum allowed for a procedure. Reimbursement will be made only for the maximum number of units allowed; BWC will not process adjustments to reimbursement above the maximum.	X		X	Informational			
385	The units of service for a daily rate procedure cannot exceed the days covered between the first and last dates of service on the line item. One unit per day is allowed.	This denial code applies only to hospital bills.	X		X	Obsolete			
388	Payment is denied as the diagnosis code is required when billing a HCPCS procedure.	This applies only to non-facility bills.		X		Reject Code			
389	The Number of units have been altered from the bill and reimbursed as otherwise documented by the MCO.	The MCO has additional documentation that indicates that the number of units on the bill is not accurate.	X		X	Informational			
393	Payment is denied as the date of service is after the date the bill was received.	BWC cannot reimburse future services.		X		Reject Code			
394	Payment is denied as the revenue center code is not covered by BWC.	A revenue center code was billed that is not covered by BWC.	X		X	Denial Code			
395	Payment is denied as the service does not appear to be related to an industrial injury.	This EOB is for use when the HCPCS level I, II, or III code billed is not routinely covered by BWC or is by report. Effective with the 2010 Fee Schedule (effective 10/25/2010) fee schedule, this EOB code will only be used for codes that are listed as NRC (not routinely covered) and with BR (by-report) codes that can be approved for payment by MCOs. NC (non-covered) codes will be denied with EOB 553.	X		X	Denial Code			
396	Payment is denied as the MCO's pay-to provider is not on file.	The pay-to provider on the bill does not exist in BWC's provider data base.		X		Reject Code			
397	Payment is denied as MCO's pay-to provider was not active on the DOS.	The pay-to provider number indicates that the provider was not active on the date of service.	X		X	Denial Code			
398	Physician Assistant cannot be payee.	Although BWC now enrolls physician assistants as providers (BWC provider type 3), they cannot be the pay-to provider on a bill.		X		Reject code			
399	All providers on ASC bills must be ASCs.	Both the servicing and pay-to provider numbers on an ASC bill must be ASC providers (BWC provider type 3).		X		Reject Code			
400	Payment is denied as BWC records indicate that the servicing provider was not active on the date of service.	The servicing provider number's enrollment status on the date of service was not "active."	X		X	Denial Code			
403	Payment is denied as this MCO does not exist.	BWC requires that MCOs submit their 5-digit number in the BGN segment; failure to include this segment with a valid 5-digit MCO number will result in rejection of the 837with this EOB.		X		Reject Code			
407	Payment is denied as this procedure does not warrant an assistant surgeon.	This EOB is used to identify all lines where modifiers 80 (assistant surgeon), 81 (minimum assistant surgeon) and 82 (assistant surgeon when qualified resident surgeon not available) were used inappropriately. When BWC has applied the EOB, it is using the criteria in its professional clinical editing software.	X		X	Denial Code	Changed	Clarified criteria; documented that this EOB can be used by MCOs and that this is a denial EOB.	11/18/2013

408	Payment is denied as this is considered to be part of a global fee.	Visits or procedures will be allowed if the sum of the billed amounts for visits or procedures is less than the maximum fee schedule for the identified surgical code. All bills with modifiers 54 (surgical care only), 55 (Post-operative management only) and 56 (Preoperative management only) with surgical CPT codes will be subject to this edit. When BWC applies this EOB, it uses the criteria in its professional clinical editing software.	X		X	Denial Code	Changed	Clarified criteria; documented that this EOB can be used by MCOs and that this is a denial EOB.	11/18/2013
409	Payment is denied as history shows a previously reimbursed visit with this provider within the past three years and therefore does not meet AMA "new patient" definition.	BWC uses the industry standard for this EOB - a patient can only be a new patient to a provider once in three years. When BWC applies this EOB, it uses its professional clinical editing software.	X		X	Denial Code	Changed	Clarified criteria; documented that this EOB can be used by MCOs and that this is a denial EOB.	11/18/2013
410	Payment is denied as the office/hospital visit falls within the post-surgical follow-up period.	This EOB is applied for all bills for visits/consults billed by the non-operating or operating provider, performed within the surgical global fee period that have a related diagnosis. Logic for this EOB identifies all professional services provided within the global fee period. Modifiers 54, 55, 56, and 57 will permit bypass of this edit. The global fee periods are as follows: zero (0) days, ten (10) days for certain minor procedures and Sixty (60) days for major surgeries. Payment is reduced based on the modifier billed. If no modifier is appended, payment is denied. When BWC applies this EOB, it is using its professional clinical editing software.	X		X	Denial Code	Changed	Clarified criteria; documented that this EOB can be used by MCOs and that this is a denial EOB.	11/18/2013
411	Payment is denied as the office/hospital visit falls within the pre-operative global period.	This EOB is applied to all bills for visits/consults billed by the non-operating or operating provider, performed within the surgical global fee period that have a related diagnosis. Logic for this EOB identifies all professional services provided within the global fee period. Modifiers 54, 55, 56, and 57 will permit bypass of this edit. The global fee periods are as follows: zero (0) days, ten (10) days for certain minor procedures and Sixty (60) days for major surgeries. Payment is reduced based on the modifier billed. If no modifier is appended, payment is denied. When BWC applies this EOB, it is using its professional clinical editing software.	X		X	Denial Code	Changed	Clarified criteria; documented that this EOB can be used by MCOs and that this is a denial EOB.	11/18/2013
412	Payment is denied as the set of codes listed should be grouped together under one procedure code as a panel.	This EOB is applied following review of lab procedures billed by the same provider on the same date of service to determine if they are individual components of a disease-oriented panel or an automated chemistry panel code. When BWC applies this EOB, it is using its professional clinical editing software.	X		X	Denial Code	Changed	Clarified criteria; documented that this EOB can be used by MCOs and that this is a denial EOB.	11/18/2013
429	Payment is denied. The billed procedure must be billed directly to BWC.	The billed procedure is for a service requested directly by BWC or the IC (IME, file review, etc.). These services will not be reimbursed through an MCO.	X		X	Denial Code			
430	Payment is denied. The billed procedure must be billed directly to the Pharmacy Benefits Manager	The billed procedure is for a prescription. These services will not be reimbursed through an MCO.	X			Denial Code			
443	Payment is denied as this is part of an adjustment being made pursuant to the hospital fee schedule lawsuit settlement, and when originally processed, this line was denied.	This line was denied by BWC when the bill was originally processed and is being reprocessed as a mass adjustment. This denial most often occurs when services were billed across multiple bills and some lines on each bills were denied as duplicates.			X	Denial Code			
444	Bill processed pursuant to subrogation request.	The EOB designates bills entered by BWC as part of a subrogation project.	X		X	Informational			
445	BWC RECOVERY OF MEDICAL PAYMENTS FROM EMPLOYER - Medical Only Program	This EOB will be applied by BWC in processing special BWC Recovery Adjustments resulting from direct recovery of medical dollars from employers participating in a Medical Only Program.			X	Adjustment			
447	Payment is denied as provider is not eligible for recertification.	All certified providers must be recertified periodically. During the recertification process, a provider will be in one of several in-process statuses until he or she reaches recertified, denied or lapsed status. A provider who no longer meets the requirements for certification will be put in Denied Recertification status. There will be an effective date associated with that status and bills with date of service prior to the effective date will pay. Dates of service after the effective date will deny unless approved by an MCO with override EOB 756. However, if the provider has also been terminated, then these EOBs will not be effective.	X		X	Denial Code			
448	Payment is denied as provider's certification has lapsed.	All certified providers must be recertified periodically. During the recertification process, a provider will be in one of several in-process statuses until he or she reaches recertified, denied or lapsed status. That provider will be in one of several in-process statuses until he or she reaches recertified, denied or lapsed status. A provider who fails to respond within 90 days or who requests removal from HPP will be put in Lapsed Status. There will be an effective date associated with that status and bills with date of service prior to the effective date will pay. Dates of service after the effective date will deny unless approved by an MCO with override EOB 756. However, if the provider has been also been terminated, then these EOBs will not be effective.	X		X	Denial Code			
449	Payment is denied as this service was performed by a non-BWC-certified provider.	In-state providers must be BWC-certified in order to be reimbursed for services performed on or after January 1, 1999. When appropriate, the MCO can override this EOB with override EOB 756. Out-of-state providers are not required to obtain BWC certification.	X		X	Denial Code			

450	Payment is denied as the claim was not associated with this MCO on the billed dates of service.	1. The bill was received from an MCO that never managed the claim or, 2. the date of service is after the MCO managed the claim.			X	Denial Code			
451	Payment is denied as the MCO was not certified for date of service billed.	BWC will not reimburse for service dates billed when MCO was not certified.			X	Denial Code			
452	Payment is denied as authorization for this service was requested and disapproved.	MCOs should attach this EOB if bills are received for services for which prior authorization was requested and denied.	X			Denial Code			
453	Payment is being made as prior authorization was requested and approved.	MCOs should attach this EOB to bills received for services that were pre-authorized. This will serve as documentation that the provider adhered to BWC policy for requesting prior authorization for specific services.	X			Informational			
454	Payment is denied as documentation indicates that the service was not performed.	Medical documentation submitted indicates treatment billed was not performed.	X		X	Denial Code			
455	Payment is denied as the documentation requested has not been received.	Medical documentation needed to authorize payment has not yet been received.	X			Denial Code			
456	Payment denied as documentation for supplies billed with revenue codes 270 - 279 has not been received from provider.	MCO are required to obtain and review documentation from providers for every hospital bill that contains more \$10,000 in charges for revenue codes 270 - 279. If no documentation is received, MCOs must attach this EOB and price the line(s) at 0.00.	X			Denial Code			
457	Payment denied as documentation received from provider does not substantiate use of revenue codes 270 - 279.	MCO are required to obtain and review documentation from providers for every hospital bill that contains more \$10,000 in charges for revenue codes 270 - 279. If the documentation received does not justify the use of these codes, MCOs must attach this EOB and price the line(s) at 0.00	X			Denial Code			
458	Payment authorized for revenue codes 270 - 279 following review of documentation submitted by provider.	MCO are required to obtain and review documentation from providers for every hospital bill that contains more \$10,000 in charges for revenue codes 270 - 279. If the documentation justifies the use of these codes, MCOs must attach this EOB and price the line(s) to pay.	X			Informational			
461	Payment is denied as this claim is pending settlement of medical payments. Please contact the CSS to ensure that payment of this bill is included in the settlement.	There is a 30 day waiting period in effect for this claim for settlement of medical payments. The MCO should contact the CSS per the Medical Bill Resolution policy that went into effect in July 1999.	X		X	Denial Code	Changed	Updated document to reflect that MCO can use this EOB.	11/18/2013
462	Payment is denied as this claim is pending settlement of medical payments and compensation. Please contact the CSS to ensure that this bill is included in the settlement.	There is a 30 day waiting period in effect for this claim for settlement of medical payments and compensation. The MCO should contact the CSS per the Medical Bill Resolution policy that went into effect in July 1999.	X		X	Denial Code	Changed	Updated document to reflect that MCO can use this EOB.	11/18/2013
463	Payment is denied as this claim is dismissed. The injured worker is responsible for payment of this bill.	The claim was dismissed at the request of the injured worker. The injured worker is responsible for payment for services.			X	Denial Code			
465	Payment is denied as a request to reactivate the claim was reviewed and denied.	This may only be used by the MCO to deny bills when BWC has issued a decision to deny the claim reactivation request and the services billed are related to that request.	X		X	Denial Code			
466	Payment is being made following the approval of a request to reactivate the claim.	This may be used by the MCO to process bills or request adjustments to bills that are now payable due to the granting by BWC of a claim reactivation request.	X		X	Informational			
470	Payment denied as facility bills must have a hospital provider # (type 34,35, 36, 37)	The payee number on hospital bills must belong to a hospital. The hospital provider numbers are types 34, 35, 36 and 37.		X		Reject Code			
471	ASC providers can only bill for one unit of service.	This EOB will be generated when an ASC provider bills for more than one unit of service for surgical procedures (CPT codes 10021 - 69999 and S2370 - S2371). Reimbursement will be made for one unit of service.			X	Informational			
472	Payment is denied as the medical documentation provided is not legible. Payment for these services will be reconsidered once legible documentation is submitted.	Medical documentation submitted has been determined to be illegible by at least two people. The MCO must maintain documentation of who determined the documentation was illegible.	X		X	Denial Code			
479	Payment is denied as this procedure is a duplicate of another procedure billed on this invoice.	Duplicate billing on the same invoice.	X		X	Denial Code			
481	Payment is denied as this service has already been reimbursed the maximum number of times allowed.	Procedure has been reimbursed the maximum number of times allowed.	X			Denial Code			
482	Payment is denied as this service has already been reimbursed the maximum number of times per day.	Service has been reimbursed the maximum number of times per day. Payment is denied.	X			Denial Code			
490	The payment rate for this service/supply is \$0.00 as it is a covered, bundled service under the fee schedule.	These services are not denied but are considered bundled into other services that have been provided.	X		X	Denial Code			
496	Payment is denied as an Urgent Care cannot be a servicing provider.	Type 96 (Urgent Care) providers cannot be the servicing provider on a bill. An individual must be billed as the servicing with the Urgent Care as the payee.		X		Reject Code			

503	Payment for the rental of this equipment has been made up to the allowed purchase amount.	MCOs should use this EOB when the total billed for rental equipment exceeds the amount allowed for the purchase of the equipment. While BWC no longer sets a maximum length of time for rental of items such as TENS units, MCOs are not permitted to authorize payment for rental at an amount greater than the cost to purchase the item. If a provider bills above that amount, the MCO should authorize payment at an amount that will not exceed the purchase price and attach this EOB.	X		X	Informational			
509	Payment is denied as this procedure may not be billed with other TENS codes.	Criteria are to be developed by each MCO.	X			Denial Code			
514	This bill is denied. Please re-submit form UB-92 with an authorization number.	Provider submitted bill without an authorization number. BWC used this code with pre-HPP bills.	X			Denial Code			
515	Payment is denied as the hospitalization was not authorized and unrelated charges have been identified. Please re-submit with related services only.	Hospital bill submitted without prior authorization along with additional unrelated charges.	X			Denial Code			
516	Payment is denied as the hospital bill has an incorrect authorization number. Please resubmit form UB-92 with the correct authorization number in block 63.	Hospital bill is authorized but has been billed with the incorrect authorization number. BWC used with pre-HPP bills.	X			Denial Code			
518	Payment is denied as this service is considered to be part of a global fee.	This denial code is to be used when multiple procedures in the 10000-69999 range have been billed and a service which is part of the global fee is identified.	X			Denial Code			
519	Hospital bill is being paid in full but sent to audit because no authorization was obtained.	Charges will be paid in full. Bill will be sent to audit because prior authorization was not obtained.	X			Informational			
522	Payment is denied pending receipt of report for medical review.	Reimbursement requires medical review of medical documentation.	X			Denial Code			
523	Payment is denied as payment for this service/similar service has been made to a different provider.	Injured worker was seen by another provider for same /similar service. Payment is considered duplicate.	X			Denial Code			
524	Payment is denied as a consulting physician is not permitted to treat.	Services other than a consultation were provided by consulting physician.	X			Denial Code			
525	Payment is denied as this procedure is mutually exclusive to another code billed.	Service billed	X			Denial Code			
530	Services within 72 hours of injury. Diagnosis not allowed.	The date of service is within 72 hours of the date of injury so payment is being made for a diagnosis that is not allowed in the claim. BWC policy allows services rendered within 72 hours of the date of injury to be reimbursed even if the billed diagnosis is not an allowed code. The MCO is still responsible for determining that the services were related to the industrial injury.			X	Informational			
532	Payment is denied as the number of treatments authorized has been exceeded.	If an MCO authorizes a specific number of treatments and the provider renders more than authorized, the MCO may deny the treatments that exceed the authorized amount. This is a denial EOB so it can only be attached to a line that is priced at zero. If the provider bills both authorized and unauthorized units on one line, the MCO will have to split the services into two line items. The line containing the authorized units should be priced to pay, while the line with the unauthorized services should be priced at zero with this EOB attached.	X		X	Denial Code			
533	Payment is denied while services are being reviewed by the MCO for retroactive authorization. Provider should not re-submit bill.	If an MCO receives a bill for services that require prior authorization, it may choose to consider the services for retroactive authorization. Since that may take longer than the seven days that an MCO has to submit a bill, it can deny the bill with this EOB and proceed with the retroactive review. However, as long as the bill is otherwise payable (contains no billing errors that would result in rejection or denial by BWC), the MCO cannot make the provider re-bill.	X		X	Denial Code			
534	Payment is approved following retroactive review and authorization of service.	MCOs should attach this EOB to bills or adjustments when retroactive authorization has been approved for the services.	X		X	Informational			
535	Payment is denied following retroactive review of authorization request for this service.	MCOs should attach this EOB if a bill is received after retroactive authorization is denied for the billed service.	X		X	Denial Code			
537	MCO Alternative Dispute in process for services requested. Services are not payable at this time.	If disputed services are performed and billed to the MCO prior to the rendering of a decision at MCO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 537 EOB. If the services are later authorized at the MCO level, and the decision is not appealed to the BWC, the MCO may use the 538 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.	X		X	Denial Code			
538	Treatment reimbursement approved by MCO Alternative Dispute process (no appeal) - adjustment done to process previously disputed services.	If disputed services are performed and billed to the MCO prior to the rendering of a decision at MCO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 537 EOB. If the services are later authorized at the MCO level, and the decision is not appealed to the BWC, the MCO may use the 538 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.			X	Adjustment			

539	MCO decision on ADR issue was appealed to the BWC. Services are not payable at this time.	If disputed services are performed and billed to the MCO prior to the rendering of a decision at BWC level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 539 EOB. If the services are later authorized at the BWC level, and the decision is not appealed to the DHO, the MCO may use the 540 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.	X		X	Denial Code			
540	Treatment reimbursement approved by BWC (final determination) - adjustment done to process previously disputed services.	If disputed services are performed and billed to the MCO prior to the rendering of a decision at BWC level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 539 EOB. If the services are later authorized at the BWC level, and the decision is not appealed to the DHO, the MCO may use the 540 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.			X	Adjustment			
541	BWC decision on ADR issue appealed to DHO. Services are not payable at this time.	Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at the DHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 541 EOB. If the services are later authorized at the DHO level, and the decision is not appealed to the SHO, the MCO may use the 542 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.	X		X	Denial Code			
542	Treatment reimbursement approved by DHO (final determination) - adjustment done to process previously disputed services.	Criteria: If disputed services are performed and billed to the MCO prior to the rendering of a decision at the DHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 541 EOB. If the services are later authorized at the DHO level, and the decision is not appealed to the SHO, the MCO may use the 542 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills. If an appeal is filed, no adjustments should be processed until a final decision is reached.			X	Adjustment			
543	DHO decision on ADR issue appealed to SHO. Services are not payable at this time.	If disputed services are performed and billed to the MCO prior to the rendering of a decision at the SHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 543 EOB. If the services are later authorized at the SHO level the MCO may use the 544 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills.	X		X	Denial Code			
544	Treatment reimbursement approved by SHO (final determination) - adjustment done to process previously disputed services.	If disputed services are performed and billed to the MCO prior to the rendering of a decision at the SHO level in the Alternative Dispute Resolution process, the MCO must deny the bill using the 543 EOB. If the services are later authorized at the SHO level the MCO may use the 544 EOB (along with any other pertinent EOBs) to request adjustments to the denied bills.			X	Adjustment			
551	Payment is denied because more than one diagnostic/evaluative procedure was billed for this date of service.	The billed services exceed the MCO's guidelines.	X			Denial Code			
553	Payment is denied as this procedure is not covered by BWC.	The billed procedure code will not be reimbursed by BWC; it cannot be overridden or adjusted to pay. This EOB has been inactivated by BWC since the implementation of new protocols for processing bills with non-covered and by-report codes in February 2009. Effective with the 2010 Fee Schedule (effective 10/25/2010), this EOB will again be used if an MCO submits an allowed amount for a code that is non-covered.	X		X	Denial Code			
555	Payment is denied as both work hardening and physical medicine procedures will not be reimbursed for the same date of service.	Work hardening and physical medicine procedures will not be reimbursed for the same DOS. Payment is denied.	X			Denial Code			
560	Payment is denied as documentation has not been received by MCO for presumptive authorization to apply.	BWC's presumptive approval policy requires providers to take specific steps before initiating any of the services covered by the policy. These actions include filing the FROI, filing a C-9, and notifying the MCO with 24 hours if IW will be off work more than 2 calendar days. If the provider has not completed these actions, payment will be denied by the MCO.	X			Denial Code			
561	Payment is denied as prior authorization is required for epidural injections.	Epidurals are specifically excluded from the presumptive approval policy. If provider bills for epidurals and has not received prior authorization, payment will be denied by the MCO.	X			Denial Code			
562	Payment is denied as these physical medicine/OMT/CMT services/visits exceed 12 in the initial time frame and have not been authorized.	The presumptive approval policy allows up to 12 Physical Medicine (osteopathic/chiropractic manipulation, physical therapy and acupuncture) visits within the initial time frame. Additional physical medicine services within the initial 60 days require prior authorization. If a provider bills for more than 12 physical medicine visits in the initial 60 day period but has not obtained prior authorization for them, payment will be denied by the MCO. (4/5/2011 - Description change only)	X			Denial Code			
563	Payment for this procedure is denied as prior authorization is required for more than three injections in the claim's initial time frame.	The presumptive approval policy allows up to 3 injections within the initial time frame. Additional injections within the initial time frame require prior authorization. If a provider bills for more than 3 injections in the initial period but has not obtained prior authorization for them, payment will be denied by the MCO.	X			Denial Code			

564	Payment is denied as these physical medicine/OMT/CMT services exceed the initial time frame.	The presumptive approval policy covers only the initial timeframe; services provided after that time frame are subject to normal prior authorization requirements - even if the injured worker has not received the maximum number of treatments allowed by presumptive authorization. If a provider renders services after the initial period but does not obtain prior authorization, payment will be denied by the MCO.	X			Denial Code			
565	Payment is denied as prior authorization is required for psychiatric &/or chronic pain programs.	Psychiatric and chronic pain programs are not included in the presumptive approval policy and always require prior authorization. If a provider bills for these services but has not received prior authorization for them, payment will be denied by the MCO.	X			Denial Code			
566	Payment is denied as prior authorization is required as the diagnostic test exceeds the claims initial time frame.	The presumptive approval policy covers only the initial time frame; services provided after that time frame are subject to normal prior authorization requirements - even if the injured worker has not received the maximum number of treatments allowed by presumptive authorization. If a provider renders services after the initial 60 day period but does not obtain prior authorization, payment will be denied by the MCO.	X			Denial Code			
567	Payment for the purchase of this equipment has been made up to the allowed purchase amount.	MCOs should use this EOB when the amount billed for the purchase of equipment exceeds the maximum allowed purchase price. The MCO should authorize payment at an amount that will not exceed the allowed purchase price and attach this EOB.	X		X	Informational			
568	Payment is denied as this service or supply has been previously reimbursed up to the maximum allowed.	This EOB can be used if a provider re-bills in an attempt to obtain additional payment for services or supplies previously reimbursed for the maximum allowed (either maximum dollar amount or maximum number of occurrences).	X			Denial Code			
579	Payment is denied as the billed diagnosis code is in a non-payable status in this claim.	This EOB will be sent when the billed diagnosis code is in alleged, allow/appeal, disallow/appeal, dismissed or hearing status. These statuses cannot be overridden.			X	Denial Code			
601	Payment is denied as the ICD-9 code indicates a condition that is not a part of the allowed condition in the claim.	Services are billed for a condition that is not allowed in the claim. Claim may need to be amended if treatment is for the industrial injury.	X			Denial Code			
602	Payment is denied as records indicate that both inpatient and outpatient services have been billed for the same time span.	According to BWC records a UB-92 has been submitted for both IP and OP services for the same covered dates.	X			Denial Code			
603	Payment is denied because the diagnosis code billed does not appear to be related to the industrial injury.	An ICD-9-CM code was billed that is not related to the industrial injury.	X			Denial Code			
604	Payment is denied as self-insuring employers pay their own bills directly. Rebill the self-insuring employer.	Used only for pre-HPP bills.	X			Denial Code			
605	Payment is denied as this claim is in a non-payable status.	BWC uses this EOB in denying bills for claims which have not yet been determined.			X	Denial Code			
606	Payment is denied because bill contains no prior authorization number. If this is a BWC-authorized service, contact the Customer Service Team	Used only for pre-HPP bills.				Denial Code			
607	Payment is denied as procedure will be reimbursed one line item per date of service. This is regardless of date of service or number of body areas. CPT language includes "one or more areas."	Procedure code has been reimbursed on this date of service. Only one unit will be paid according to language in the 1996 CPT manual.	X			Denial Code			
609	Payment denied as reactivation denied by the Industrial Commission.	There will be a note in V3 (viewable by the MCO via EDA) when reactivation has been formally denied by the Industrial Commission. If the MCO receives bills and needs a 148 in order to review them, it should request reactivation for bill review purposes. If the MCO denies the bills, they should be priced at 0.00 and submitted with EOB 609. The MCO must contact the CSS if it is considering paying bills for a claim that has had reactivation denied by the Industrial Commission.	X		X	Denial Code			
610	Denied-IW has intervening injury and/or newer claim.	A BWC investigation has uncovered that the injured worker sustained an intervening injury, which may or may not have resulted in a new Workers Compensation claim. Current services are the result of the intervening injury and are not causally related to the claim that was billed.	X		X	Denial Code			
611	Payment denied - prior authorization for service(s) was requested and denied.	If prior authorization was requested but was denied by the MCO, price the service(s) at 0.00 and attach this EOB.	X		X	Denial Code			
612	Payment denied as medical documentation does not support medical necessity of continuing evaluation/management services in this claim.	Evaluation/management services do not require prior authorization but at any stage of a claim's life cycle, they must be medically necessary.	X		X	Denial Code			
614	Claim is managed by BWC's catastrophic claim vendor. The MCO has forwarded bills to the vendor. Please contact Paradigm Outcomes at 800-676-6777 for assistance.	To be used when MCO receives a bill for a claim that is being managed by BWC's catastrophic claim vendor. The MCO should deny the bill with this EOB and submit on the 837, but should also forward the bill to Paradigm.	X		X	Denial	Added	New EOB to document that the bill cannot be paid through the MCO process.	4/1/2013
620	Payment denied due to an error on the bill. Services billed are covered services, but the amount assigned is zero.	This EOB is used when there has been a billing error on the line item. The services are covered but the place of service billed is inappropriate for the service.	X		X	Denial Code			

621	Revenue code is not valid with the procedure code billed.	On facility bills, the Revenue Center Code and the procedure code billed must be a valid combination. This code is being used to deny bills under OPPS. (1/1/2011 effective date applies only to criteria description.)			X	Informational			
631	Payment is denied as this service is not allowed in this claim.	Procedure billed is restricted in this claim. The Customer Service Team will inform the MCO when services have been limited by a BWC order.	X		X	Denial Code			
632	Payment is denied as the services allowed in this claim have been limited by an Industrial Commission order.	Procedure billed is restricted in this claim. The Customer Service Team will inform the MCO when services have been limited by an Industrial Commission order.	X		X	Denial Code			
633	Payment is denied as the services in this claim have been limited by a court order.	Procedure billed is restricted in this claim. The Customer Service Team will inform the MCO when services have been limited a court order.	X		X	Denial Code			
634	Payment is denied as physician review has determined that this service was not medically necessary or is not covered in this claim.	Bill has been reviewed with medical documentation.	X		X	Denial Code			
635	Payment is denied. Please rebill with appropriate "J" code.	"J" codes are accepted for dates of service on or after 08-01-96. Bill must be resubmitted with the appropriate code. Used only for pre-HPP bills.				Denial Code			
636	Invalid diagnosis code	Invalid diagnosis code. This means that this code was either expired prior to the service date or became affective after the service date. When BWC applies this EOB it is based on logic in its outpatient clinical editor.	X		X	Denial Code	Changed	Clarified criteria and updated to reflect that MCOs can send this EOB on outpatient bills starting 11/25/2013.	1/1/2011
637	Diagnosis and age conflict	Used when billed diagnosis and IW age are in conflict. BWC applies this EOB based on criteria in its outpatient code editor. MCOs may use this EOB on any bill type where this condition is met.	X		X	Denial Code	Changed	Clarified criteria and updated to reflect that MCOs can send this EOB starting 11/25/2013.	1/1/2011
638	Diagnosis and sex conflict	This EOB is applied when billed diagnosis and IW gender are in conflict. When BWC applies this EOB, it is based on criteria in its outpatient coding editor. MCOs may apply this EOB on any bill type where the criteria are met.	X		X	Denial Code	Changed	Clarified criteria and updated to reflect that MCO can use this EOB starting 11/25/2013.	1/1/2011
639	E-diagnosis code can not be used as principal diagnosis	E-diagnosis code can not be used as principal diagnosis EOB effective 1/1/2011.			X	Denial Code			
640	Invalid procedure code	Invalid procedure code. EOB effective 1/1/2011.			X	Informational			
641	Procedure and sex conflict	This EOB is applied when the billed procedure and IW gender are in conflict. When BWC applies this EOB, it is based on criteria in its outpatient coding editor. MCOs may apply this EOB on any bill type where the criteria are met.	X		X	Denial Code	Changed	Clarified criteria and updated to reflect that MCO can use this EOB starting 11/25/2013.	1/1/2011
642	Non-covered service	Non-covered service. EOB effective 1/1/2011.			X	Informational			
643	Inappropriate specification of bilateral procedure	Inappropriate specification of bilateral procedure. EOB effective 1/1/2011.			X	Denial Code			
644	Mutually exclusive procedure that is not allowed even if appropriate modifier is present	Mutually exclusive procedure that is not allowed even if appropriate modifier is present. EOB effective 1/1/2011.			X	Denial Code			
645	Component of a comprehensive procedure that is not allowed even if appropriate modifier is present	Component of a comprehensive procedure that is not allowed even if appropriate modifier is present. EOB effective 1/1/2011.			X	Denial Code			
646	Medical visit on same day as a type T or S procedure without modifier 25	Medical visit on same day as a type T or S procedure without modifier 25. EOB effective 1/1/2011.			X	Denial Code			
647	Invalid modifier	Invalid modifier. EOB effective 1/1/2011.			X	Denial Code			
648	Invalid date	Invalid date. EOB effective 1/1/2011.			X	Denial Code			
649	Invalid age	Invalid age. EOB effective 1/1/2011.			X	Denial Code			
650	Invalid sex.	Invalid sex. EOB effective 1/1/2011.			X	Denial Code			
651	Only incidental services reported	Only incidental services reported. EOB effective 1/1/2011.			X	Denial Code			
652	Code not recognized by Medicare; alternate code for same service available	Code not recognized by Medicare; alternate code for same service available. EOB effective 1/1/2011.			X	Informational			
653	Partial hospitalization service for non-mental health diagnosis	Partial hospitalization service for non-mental health diagnosis. EOB effective 1/1/2011.			X	Denial Code			
654	Insufficient services on day of partial hospitalization	Insufficient services on day of partial hospitalization. EOB effective 1/1/2011.			X	Denial Code			
655	Only mental health education training services provided	Only mental health education training services provided. EOB effective 1/1/2011.			X	Denial Code			
656	Terminated bilateral procedure or terminated procedure with units greater than one	Terminated bilateral procedure or terminated procedure with units greater than one. EOB effective 1/1/2011.			X	Denial Code			
657	Inconsistency between implanted device or administered substance and implantation or associated procedure	Inconsistency between implanted device or administered substance and implantation or associated procedure. EOB effective 1/1/2011.			X	Denial Code			
658	Mutually exclusive procedure that would be allowed if appropriate modifier were present	Mutually exclusive procedure that would be allowed if appropriate modifier were present. EOB effective 1/1/2011.			X	Denial Code			
659	Component of comprehensive procedure that would be allowed if appropriate modifier were present	Component of comprehensive procedure that would be allowed if appropriate modifier were present. EOB effective 1/1/2011.			X	Denial Code			
660	Invalid revenue code	Invalid revenue code. EOB effective 1/1/2011.			X	Denial Code			
661	Multiple medical visits on same day with same revenue code without condition code G0	Multiple medical visits on same day with same revenue code without condition code G0. EOB effective 1/1/2011.			X	Denial Code			
662	Transfusion or blood product exchange without specification of blood product	Transfusion or blood product exchange without specification of blood product. EOB effective 1/1/2011.			X	Denial Code			

663	Observation revenue code on line item with non-observation HCPCS code	Observation revenue code on line item with non-observation HCPCS code. EOB effective 1/1/2011.			X	Denial Code			
664	Partial hospitalization condition code 41 not approved for type of bill	Partial hospitalization condition code 41 not approved for type of bill. EOB effective 1/1/2011.			X	Denial Code			
665	Service is not separately payable.	Service is not separately payable. EOB effective 1/1/2011.			X	Denial Code			
666	Billed revenue center code requires HCPCS code.	Revenue center requires HCPCS. EOB effective 1/1/2011. When BWC applies this EOB it is based on logic in its outpatient coding editor.	X		X	Denial Code	Changed	Changed to clarify criteria and reflect that MCOs can use this EOB.	11/18/2013
667	Non-covered based on statutory exclusion	Non-covered based on statutory exclusion. EOB effective 1/1/2011.			X	Informational			
668	Codes G0378 and G0379 only allowed with type 13x or 85x	Codes G0378 and G0379 only allowed with type 13x or 85x. EOB effective 1/1/2011.			X	Denial Code			
669	Multiple codes for the same service	Multiple codes for the same service. EOB effective 1/1/2011.			X	Denial Code			
670	Non-reportable for site of service	Non-reportable for site of service. EOB effective 1/1/2011.			X	Denial Code			
671	G0379 only allowed with G0378	G0379 only allowed with G0378. EOB effective 1/1/2011.			X	Denial Code			
672	Use of modifier CA with more than one procedure not allowed	Use of modifier CA with more than one procedure not allowed. EOB effective 1/1/2011.			X	Denial Code			
673	Service can only be billed to the DMERC	Service can only be billed to the DMERC. EOB effective 1/1/2011.			X	Denial Code			
674	Code not recognized by Medicare; alternate code for same service available	Code not recognized by Medicare; alternate code for same service available. EOB effective 1/1/2011.			X	Informational			
675	This OT code only billed on partial hospitalization claims	This OT code only billed on partial hospitalization claims. EOB effective 1/1/2011.			X	Denial Code			
676	AT service not payable outside of the partial hospitalization program	AT service not payable outside of the partial hospitalization program. EOB effective 1/1/2011.			X	Denial Code			
677	Revenue code not recognized Medicare	Revenue code not recognized Medicare. EOB effective 1/1/2011.			X	Denial Code			
678	Code requires manual pricing	Code requires manual pricing. EOB effective 1/1/2011.			X	Denial Code			
679	Service provided prior to FDA approval	Service provided prior to FDA approval. EOB effective 1/1/2011.			X	Denial Code			
680	CA modifier requires patient status code 20	CA modifier requires patient status code 20. EOB effective 1/1/2011.			X	Denial Code			
681	Claim lacks required device code	Claim lacks required device code. EOB effective 1/1/2011.			X	Denial Code			
682	Service not billable to the Fiscal Intermediary	Service not billable to the Fiscal Intermediary. EOB effective 1/1/2011.			X	Informational			
683	Incorrect billing of blood and blood products	Incorrect billing of blood and blood products. EOB effective 1/1/2011.			X	Denial Code			
684	Units greater than one for bilateral procedure billed with modifier 50	Units greater than one for bilateral procedure billed with modifier 50. EOB effective 1/1/2011.			X	Denial Code			
685	Trauma response critical care code without revenue code 068x and CPT 99291	Trauma response critical care code without revenue code 068x and CPT 99291. EOB effective 1/1/2011.			X	Denial Code			
686	Claim lacks allowed procedure code	Claim lacks allowed procedure code. EOB effective 1/1/2011.			X	Denial Code			
687	No radiopharm (packaged) with diagnostic imaging procedure	No radiopharm (packaged) with diagnostic imaging procedure. EOB effective 1/1/2011.			X	Denial Code			
688	Incorrect billing of revenue code with HCPCS code	Incorrect billing of revenue code with HCPCS code. EOB effective 1/1/2011.			X	Denial Code			
689	Mental health code not approved for partial hospitalization	Mental health code not approved for partial hospitalization. EOB effective 1/1/2011.			X	Denial Code			
690	Mental health service not payable outside partial hospitalization program	Mental health service not payable outside partial hospitalization program. EOB effective 1/1/2011.			X	Denial Code			
691	Unit exceeds Medically Unlikely Edit maximum	BWC will use the Medically Unlikely Edits (MUEs) released by CMS. The CMS MUE program was developed to reduce the paid claims error rate for Medicare claims. MUEs are designed to reduce errors due to clerical entries and incorrect coding based on anatomic considerations, HCPCS/CPT code descriptors, CPT coding instructions, established CMS policies, nature of a service/procedure, nature of an analyte, nature of equipment, and unlikely clinical treatment. MUEs are updated quarterly and can be downloaded from the CMS web site. EOB effective 1/1/2011.			X	Denial Code			
692	Claim lacks required primary procedure code.	Claim lacks required primary procedure code. EOB effective 4/1/2012			X	Denial Code			
693	Claim lacks required Device or procedure code.	Claim lacks required Device or procedure code. EOB effective 4/1/2012			X	Denial Code			
701	The procedure code billed has been changed to reflect the more appropriate code for the procedure or service rendered.	The procedure code billed by the provider did not conform to coding standards. Price this line item at zero and add new line item with replacement code and EOB 769.	X			Denial Code			
702	The modifier billed is inappropriate for this CPT code. Services have been paid at the allowable amount. Billing without a modifier will expedite reimbursement for similar services.	A -22 modifier was used with a procedure code that is ineligible for use with this modifier.	X			Informational			
703	The number of days billed exceeds the days authorized. Payment has been made pending an audit of this billing.	The number of days authorized is less than the number of days billed. Payment has been made pending an audit.	X			Informational			
704	Payment has been made at BWC's fee schedule rate. Medical documentation submitted does not justify use of the unusual services modifier.	A -22 modifier was used, but medical documentation does not indicate that unusual services were rendered.	X			Informational			
705	Payment is being made to comply with an Industrial Commission order.	The service would not normally be authorized, but an Industrial Commission order requires reimbursement of the service.	X			Informational			

706	The unlisted procedure code has been changed following physician review of documentation submitted with invoice.	The procedure code billed by the provider did not conform to coding standards. Price this line item at zero and add new line item with replacement code and EOB 769.	X			Denial Code			
707	This claim was in the Medical Only Program. This item has been priced to reflect partial payment by the employer.	Employer has reimbursed the first \$1,000/5,000/15,000 of injured workers claim. BWC is responsible for additional reimbursement.	X			Informational			
710	This bill has been adjusted following retrospective review.	After further review, this bill has been adjusted.			X	Informational			
711	The ICD-9 code billed is not allowed in this claim; however, following a review of the bill, payment for emergency or diagnostic services is being made on a one-time basis.	Use in addition to 776.	X			Informational			
712	The ICD-9 code billed is not allowed in this claim; however, following a review of the bill, payment for treatment of a time-limited complication is being made on a one-time basis.	Use in addition to 776.	X			Informational			
713	MCO-priced amount is BWC fee schedule amount.	Use of this code is optional. It was created at the request of several MCOs.	X			Informational			
714	This bill has been priced according to this MCO's pricing policies.	This code has been created at MCO request.	X			Informational			
716	No payment decision can be made at this time as a determination of relatedness has not yet been made.	This EOB will be used by BWC when there is an ongoing investigation of relatedness of current activity or period of disability to original injury. The payment is neither approved nor disapproved but the bill is being released with \$0.00 payment and this EOB so that provider will be advised of status.			X	Informational			
717	MCO requests this bill be suspended for review and pricing.	The MCO process for bills on review is the same as for claims on review. The MCO still needs Medical Policy approval and a note must be placed in V3 by Medical Policy indicating approval. The MCO will then send the bill to Cambridge with EOB 717 attached to it. The MCO will send a secured document e-mail to MBASUPV with the claim number, document number, date of service, code suspended, dollar amount and V3 note date, and request MB&A manually price and release the bill. MB&A will review the request and release the bill with the appropriate EOBs.	X		X	Informational			
720	BWC OPPS Hospital	This hospital is not eligible for any special pricing add-on payment.			X	Informational			
721	Hospital is a Cancer facility	This Hospital has been identified by the OPPS grouper as an Cancer facility and is eligible for a add-on payment			X	Informational			
722	Hospital is a Children's facility	This hospital has been identified by the OPPS grouper as an Children's facility and is eligible for a add-on payment			X	Informational			
723	Hospital is a Sole Community/EACH facility	This hospital has been identified by the OPPS grouper as an Sole Community facility and is eligible for a add-on payment			X	Informational			
724	Hospital is a Critical Access facility	This hospital has been identified by the OPPS grouper as an Critical Access facility and is eligible for a add-on payment			X	Informational			
732	Anesthesia base units have been applied to the payment	Effective for Dates of service 01/01/2013. Indicates a line for anesthesia services that BWC included the anesthesia base units in the calculation for payment			X	Informational			1/1/2013
733	Anesthesia base units applied and MCO priced amount is less than BWC Fee Schedule.	Effective for Dates of service 01/01/2013. Indicates a line for anesthesia services that BWC calculated the fee schedule amount using the Anesthesia base units and where the MCO priced amount is less than the BWC fee schedule amount.			X	Informational			1/1/2013
734	Diagnosis present on admission indicator is empty - defaulted to N.	Applied to inpatient bills when a diagnosis code is received with no present on admission indicator. Those codes will be processed by BWC with a defaulted POA of N.			X	Informational			2/1/2013
735	Diagnosis present on admission indicator is invalid - defaulted to N.	Effective 2/1/2013 for inpatient bills when a diagnosis code is received with an invalid present on admission indicator. MCOs should default the invalid POA to N and apply this EOB.	X		X	Informational			2/1/2013
741	Reimbursement is discounted in accordance with OAC Rule 4123-6-16.3.	In accordance with OAC Rule 4123-6-16.3, this EOB indicates retroactive medical treatment and that the payment has been reduced.			X	Informational			
742	Reimbursement is discounted in accordance with OAC Rule 4123-6-16.3.	Applied by the MCO in accordance with OAC Rule 4123-6-16.3 to indicate retroactive medical treatment. The payment will be reduced.	X			Informational			
743	Override for claims on joint BWC-MCO review.	This EOB attests that the MCO has conferred with the BWC contact in this claim and that both parties agree that it is appropriate to reimburse treatment in this claim. This EOB overrides EOB 284.	X		X	Override			1/1/2011
744	Override for suspended medical benefits	This EOB should be used to authorize payment for life-sustaining treatment when medical benefits have been otherwise suspended in a claim. It serves as an override for EOB 211.	X		X	Override			
745	Payment is authorized for the same services by different providers on the same date.	The MCO will use this to authorize payment of lines that would normally be denied with EOB 098. With this EOB, the MCO attests that it has verified that the services are not duplicates of previously authorized bills.	X		X	Override			

746	Provider not found on MCO panel on the date of service.	This EOB will be used if the MCO-priced amount is different from the provider's billed amount and the provider is not a panel provider. BWC assumes that the MCO considers the provider a panel provider if the MCO price is different from the billed price. This EOB may indicate that the MCO's records and BWC's records do not match. A bill containing this EOB was priced using non-panel criteria. The EOB will not be generated if there is no fee associated with a particular procedure billed.	X		X	Informational			
749	Payment has been authorized to a non-BWC certified provider on a one-time basis.	This EOB is no longer valid; use EOB 756 instead	X			Obsolete	Changed	Change to document that BWC no longer uses this EOB.	10/13/2013
750	Payment has been authorized to a non-BWC certified provider for continuing care of a pre-10/20/93 injury.	This EOB is no longer valid; no override is needed for services for gamma claims.	X			Override			
751	Procedure was reimbursed up to the maximum number allowed per day.	This EOB should be used to indicate that the provider billed in excess of the maximum units allowed. The priced amount will equal the reimbursement level for the maximum allowed.	X			Informational			
752	Payment has been made for a BWC non-covered service.	MCO use of this EOB was discontinued for service dates of 2/19/2009 and later. This override EOB was originally used to indicate that a BWC non-covered service had been reimbursed. Effective 8/31/2010, MCOs may use this EOB at the line level to approve services in accordance with the new NC/BR policy. For dates of service covered by the 2010 Fee Schedule (effective 10/25/2010), this EOB will be used to approve services that are in the NRC category. Non-covered services (NC) will be denied with EOB 553 and cannot be approved with 752.	X			Override			
753	These services were rendered as part of an authorized rehabilitation program.	This override EOB must be used when the services rendered are to be charged to BWC's rehabilitation fund.	X			Override			
756	Payment has been authorized to a non-BWC certified provider on a one-time basis or due to special circumstances.	This override EOB must be used when no BWC-certified provider is accessible on a one-time basis or for continuing treatment.	X			Override			
757	Procedure with modifier paid at maximum allowed.	Payment is being made for a procedure with a modifier at the maximum allowed. This EOB may appear when charges are billed with the -22 modifier.			X	Informational			
758	This is the principal procedure of multiple procedures billed on this date of service.	This EOB must be used to indicate the principal procedure when multiple procedures in the 10000-69999 CPT code range are billed by a provider for a single date of service.	X			Informational			
759	This is the second procedure of multiple procedures billed on this date of service.	This EOB must be used to indicate the second procedure when multiple procedures in the 10000-69999 CPT code range are billed by a provider for a single date of service.	X			Informational			
760	This is the third procedure of multiple procedures billed on this date of service.	This EOB must be used to indicate the third procedure when multiple procedures in the 10000-69999 CPT code range are billed by a provider for a single date of service.	X			Informational			
761	This is the fourth procedure of multiple procedures billed on this date of service.	This EOB must be used to indicate the fourth procedure when multiple procedures in the 10000-69999 CPT code range are billed by a provider for a single date of service.	X			Informational			
762	This is the fifth procedure of multiple procedures billed on this date of service.	This EOB must be used to indicate the fifth procedure when multiple procedures in the 10000-69999 CPT code range are billed by a provider for a single date of service.	X			Informational			
764	Payment is denied as this procedure code is part of the service billed with a different code.	This EOB is to be used when unbundled or incidental services are identified by the MCO. The MCO-priced amount should be \$0.00.	X			Denial Code			
765	This procedure has been added as it covers unbundled charges originally billed by the provider.	This EOB is to be used to identify a procedure which has been added by the MCO. It is to be used when the MCO determines that the provider had unbundled charges. The MCO should total the provider's charges for unbundled items and list them as the provider-billed charges in the added line-item detail.	X			Informational			
766	Payment is denied as this procedure is mutually exclusive to another procedure billed.	This EOB is to be used to indicate that payment is denied for services which are contraindicated with other services billed by the provider.	X			Denial Code			
767	This unlisted code has been replaced by another, more specific code.	This EOB is to be used when payment is denied for services billed with an unlisted code because another, more specific code describes the services. The MCO should price services billed with this code at \$0.00. The replacement code should be added with EOB 768.	X			Denial Code			
768	This procedure has been added to replace an unlisted code.	This EOB is to be used when the MCO has identified a specific code to describe services billed with an unlisted or miscellaneous procedure code. The MCO should list the charges originally billed with the unlisted code as the provider's billed charges.	X			Informational			
769	This procedure has been added to replace a procedure that was billed incorrectly.	Use when reimbursing an added procedure that replaces a procedure that did not meet CPT or HCPCS coding standards.	X			Informational			
770	Unbundled or unlisted code provider charges have been transferred to a rebundled or specific code.	May be attached with EOB 767 on a line that has been priced at \$0.00	X			Denial Code			

771	MCO is reimbursing IW for these services.	MCOs should attach this EOB to 837s when it wants to reimburse the injured worker. This EOB was created to enable MCOs to identify when the approved payment on an 835 should be made to an injured worker rather than to a provider. The 837 must include valid BWC provider numbers in the servicing and pay-to provider fields.	X			Informational			
772	MCO is reimbursing employer for these services.	MCOs should attach this EOB to 837s when it wants to reimburse the injured worker. This EOB was created to enable MCOs to identify when the approved payment on an 835 should be made to an employer rather than to a provider. The 837 must include valid BWC provider numbers in the servicing and pay-to provider fields.	X			Informational			
773	Multiple lines billed by the provider have been bundled into a single line item.	MCOs should attach this EOB to 837s when the provider has billed a single procedure multiple times for a single date of service, but the service should have been billed on a single line with multiple units (e.g. bilateral radiology procedures). The line containing this EOB should also contain the multiple units of service and appropriate dollar amounts.	X		X	Informational			
774	MCO is reimbursing a 3rd party for these services.	MCOs should attach this EOB to 837s when it wants to reimburse a third party. This EOB was created to enable MCOs to identify when the approved payment on an 835 should be made to a third party rather than to a provider. The 837 must include valid BWC provider numbers in the servicing and pay-to provider fields.	X			Informational			
775	Payment denied as line item charges have been bundled into charges for another procedure code.	This is the companion EOB to 773. This should be attached to lines that are to be bundled into the line containing 773. The MCO priced amount for the line(s) containing 775 must be zero.	X		X	Denial Code			
776	Payment is being made for a non-allowed, but related condition.	This override EOB must be used when the MCO reimburses services for a condition that is not allowed in the claim.	X			Override			
777	Payment exception. ICD code is expired for this date of service. Future submission must contain the correct code that reflects the condition being treated.	As of July 2001, MCOs are no longer permitted to override EOB 343 which posts when an invalid/non-specific diagnosis code is billed. MCOs must deny these codes upon initial submission but may request adjustments using this EOB. BWC expects that this will be used mainly for payment of emergency services that are not rendered within 72 hours of a claim's date of injury.	X		X	Adjustment			
782	Vocational Rehabilitation local code	MCO obtained the necessary information in determining payment of this code. MCO researched into code and reasonable reimbursement is documented in claim. MCO approves payment.	X			Informational			To be determined - BWC has not yet implemented the change in the Voc By Report process
783	Payment is being made in an occupational disease claim for related services prior to the date of diagnosis.	Treatment of a condition prior to its diagnosis and allowance as a claim is compensable in occupational disease cases.	X			Override			
784	Bill cannot be considered for payment until the injured worker appears for a BWC exam.	BWC will notify an MCO if an injured worker fails to appear for a BWC exam. Routine services should be suspended until notice from BWC. Bills submitted during this period should be priced at zero and submitted to BWC with this EOB.	X		X	Denial Code			
785	MCO authorized payment of additional procedures.	The MCO should attach this EOB if it approves more than 5 procedures per date of service.			X	Adjustment			
786	Payment denied as charges for hot/cold packs should be bundled with another procedure	Effective October 1, 2003 BWC no longer reimburses for hot or cold packs. This will be an informational EOB (do not price at 0.00) until March 2004. At that time it will be reclassified as a denial EOB and MCOs will be required to price the line item at 0.00.	X		X	Denial Code			
787	Prosthetics	MCO obtained the necessary information to make an informed decision and fully agrees with reimbursement. MCO approves payment.	X		X	Informational			
788	J3490 Medication	MCO obtained the necessary information to make an informed decision. Information supporting MCO decision is imaged into claim. MCO approves dollar amount for reimbursement	X		X	Informational			
789	Unlisted CPT codes	MCO obtained the necessary information in determining payment of this code. MCO research into code and cost is documented in claim. MCO approves payment	X		X	Informational			
790	Unlisted HCPCS codes	MCO obtained the necessary information in determining payment of this code. MCO research into code and reasonable reimbursement is documented in claim. MCO approves payment	X		X	Informational			
791	Other coded services/procedure requiring EOB 752 override	MCO reviewed and approves payment	X		X	Informational			
792	Out-of-State Non-Certified Provider payment above fee schedule.	MCO has justified higher reimbursement and approves payment MCO information supporting decision is imaged into claim and documented in V3 notes. For BR/NC/NRC codes, this EOB must be added in addition to EOB 860.	X		X	Informational			
798	This bill was priced without regard to MCO's pricing EOBs.	If an MCO attaches multiple surgical pricing EOBs (758 - 761) to one line item, those EOBs will be ignored and the bill will be priced according to BWC guidelines.			X	Informational			
802	A bill/header level EOB is required on adjustments to identify the origin of the request.	This EOB will not be used until BWC begins processing adjustments via EDI.			X	Adjustment			

803	Request for adjustment received with an invalid MCO invoice number. MCO invoice number must match original.	This EOB will not be used until BWC begins processing adjustments via EDI.			X	Adjustment			
804	There is an adjustment already in process for this bill.	This EOB will not be used until BWC begins processing adjustments via EDI.			X	Adjustment			
805	MCO number on adjustment request does not match MCO number on previous bill record.	This EOB will not be used until BWC begins processing adjustments via EDI.			X	Adjustment			
806	MCO initiated adjustment.	This EOB will be automatically applied during the adjustment process.			X	Adjustment			
807	BWC initiated adjustment.	This EOB will be applied when BWC initiates an adjustment.			X	Adjustment			
808	Request for adjustment was received without a valid EOB identifying the source of the request. Please attach appropriate EOBs when requesting adjustment to previously adjudicated invoice.	This EOB will not be used until BWC begins processing adjustments via EDI.			X	Adjustment			
809	A request was made to adjust bill information without the required adjustment EOB.	This EOB will not be used until BWC begins processing adjustments via EDI.			X	Adjustment			
810	Billed in error. Reverse entire bill.	The EOB should be used when an entire bill was paid in error.			X	Adjustment			
811	Claim number for this IW changed.	This EOB should be used when an incorrect claim number was used. It is critical that an adjustment be requested in this type of situation so that the payment will be accounted for with the correct employer.			X	Adjustment			
812	Services not rendered.	This EOB should be used if an MCO determines that a previously reimbursed service was not rendered.			X	Adjustment			
813	Services not industrially related.	MCO may use to deny a bill received after a reactivation review has determined that services requested are not related to the claim.	X		X	Denial Code			
814	Claim disallowed.	This EOB should be used if a payment was made in a claim that was subsequently disallowed.			X	Adjustment			
815	Claim is now allowed.	This EOB should be used if previously denied services were actually for an allowed claim.			X	Adjustment			
816	Invalid adjustment EOB.	This EOB will not be used until BWC begins processing adjustments via EDI.			X	Adjustment			
817	Payment is being charged to the surplus fund.	This EOB may only be used by BWC staff. It will be attached to adjustments if a paid bill is adjusted to remove charges from the employer's risk to the Surplus Fund. This may be due to a claim status change from allowed to disallowed or as mandated by the Industrial Commission.			X	Adjustment			
818	Adjustment to change servicing provider number.	This EOB will be used if the incorrect servicing provider was indicated on the original bill.			X	Adjustment			
819	Changed the total billed amount due to line item changes.	This EOB should be used to correct the total billed amount as the direct result of line item changes.			X	Adjustment			
820	Line item billed in error.	This EOB should be used if a line item was billed in error.			X	Denial Code			
821	Services not rendered for this line item.	This EOB should be used if the MCO determines a line item service was not rendered.			X	Denial Code			
822	Services not industrially related for this line item.	This EOB should be used if the MCO determines that a line-item service was not related to the industrial injury or disease.			X	Denial Code			
823	Line item deleted as a result of bundling of charges.	This EOB should be used if an MCO determines that the provider had unbundled charges.			X	Denial Code			
824	Date of service changed.	This EOB should be used if a date of service was incorrect on the original bill.			X	Adjustment			
825	The charges on this line item have been denied as this service occurred during the follow-up period and should be part of the global fee.	This EOB should be used to correct reimbursement of unbundled charges.			X				
826	Revenue or procedure code changed due to input error on the original line item.	This EOB should be used if there was an input error in the service code billed.			X	Adjustment			
827	Revenue or procedure code changed due to medical coding error on original line item.	This EOB should only be used when the reason to change the revenue or procedure code billed was caused by a medical coding error. Explanation of the medical coding error should be documented on the request for adjustment form.			X	Adjustment			
828	Service code is part of a global fee.	This EOB should be used if a service was performed during the follow-up period and should be considered part of the global fees.			X	Adjustment			
829	Service code authorized by IC.	This EOB should be used if a service code that is not normally covered is being reimbursed as a result of an IC order.			X	Adjustment			
830	Service code denied by IC.	This EOB should be used if a service code has been denied by an IC order and payment is being recouped.			X	Adjustment			
831	Services rendered as a part of BWC authorized rehab program.	This EOB should be used if services were authorized as part of the injured worker's rehab program.			X	Adjustment			
832	Modifier changed due to input error.	This EOB should only be used when the modifier on the original invoice was incorrect due to an input error.			X	Adjustment			
833	Modifier changed due to medical coding error.	This EOB should be used only when the modifier on the original invoice was incorrect due to a medical coding error. Explanation of the error should be documented on the request for adjustment form.			X	Adjustment			
834	Changed the units billed due to input error.	This EOB should be used when the units on the original invoice were incorrect due to an input error.			X	Adjustment			
835	Amount billed for line item changed due to input error.	This EOB should only be used when the amount billed on the original invoice was incorrect due to an input error.			X	Adjustment			
836	Amount billed for line item changed due to medical coding error.	This EOB should only be used when the amount billed on the original invoice was incorrect due to a medical coding error. Explanation of the medical coding error should be documented on the request for adjustment form.			X	Adjustment			

837	MCO line item priced amount changed due to input error.	This EOB should be used when the MCO line item billed on the original invoice was incorrect due to an input error.			X	Adjustment			
838	MCO line item priced amount changed due to provider/panel relationship.	This EOB should be used when the MCO line item billed was incorrect because the provider network status was identified incorrectly.			X	Adjustment			
839	MCO number of units priced amount changed due to input error.	This EOB should be used when the MCO line item number of units on the original invoice was incorrect due to an input error.			X	Adjustment			
840	MCO number of units priced amount changed due to provider/panel relationship.	This EOB should be used when the MCO line item number of units was incorrect because the provider network status was identified incorrectly.			X	Adjustment			
841	Additional line items added; previously omitted due to input error.	This EOB should be used to add line items that were OMITTED on the original submission due to an input error.			X	Adjustment			
842	Additional line items added from unbundling charges.	This EOB should be used when the MCO determines that additional line(s) must be added as a result of incorrect bundling of charges.			X	Adjustment			
843	Changed the pay-to-provider.	This EOB should be used to correct the pay-to-provider on an invoice.			X	Adjustment			
844	Changed the invoice data due to input error.	This EOB should only be used when the reason to correct and/or add header level information was caused by an input error.			X	Adjustment			
845	Changed the MCO total priced amount due to line item changes.	This EOB should only be used when the amount billed on the original invoice was incorrect due to an input error. (This is not a new or revised EOB - it was inadvertently deleted from earlier versions of this document.)			X	Adjustment			
846	Changed invoice data due to medical coding error.	This EOB should only be used when the reason to correct and/or add header level information was caused by a medical coding error. Explanation of the medical coding error should be documented on the request for adjustment form.			X	Adjustment			
847	Changed the units billed due to medical coding error.	This EOB should only be used when the units were incorrect due to a medical coding error. Explanation of the medical coding error should be documented on the request for adjustment form.			X	Adjustment			
850	BWC error in processing.	This EOB should only be used when corrections are made as a result of a BWC processing error.			X	Adjustment			
851	"Late charges" on a facility bill.	This EOB should be used to process late charges for a previously PAID facility invoice.			X	Adjustment			
852	Changed header EOB.	This EOB should be used to correct and/or add header EOBs to an invoice.			X	Adjustment			
853	Changed or added diagnosis code(s).	This EOB should be used to correct and/or add diagnosis code(s) to an invoice.			X	Adjustment			
854	Added information omitted on a facility invoice.	This EOB should only be used to add header level information to a facility invoice that was OMITTED on the original submission. (Example: add ICD principle procedure code to indicate services performed in an operating room.)			X	Adjustment			
855	Line(s) reversed due to duplicate payment.	This EOB should be used to reverse duplicate paid line(s) when prior payment has been made on the same procedure.			X	Adjustment			
856	Reversed invoice due to duplicate payment.	This EOB should be used to reverse a duplicate paid invoice when payment has been made on the exact invoice.			X	Adjustment			
857	Claim settled, but BWC responsible for this bill.	This EOB will appear on an 835 if a bill is adjusted that originally denied because the claim was in pending settlement or settled status. DO NOT ATTACH TO THE 837, DO NOT INCLUDE ON REQUEST FOR ADJUSTMENTS.			X	Adjustment			
858	Adjustment resulting from provider inquiry to BWC.	This EOB will appear on an 835 if an adjustment is initiated by BWC as the result of a provider inquiry. In general, BWC will initiate the adjustment if the bill was paid incorrectly or denied in error as the result of a BWC system error. MCOs should not refer providers to BWC for adjustments.			X	Adjustment			
860	Payment is for a negotiated fee to a non-certified, out-of-state provider.	If an MCO determines that a non-certified out-of-state provider should be reimbursed more than the BWC fee schedule, this EOB must be attached to the adjustment by the MCO when the adjustment is submitted. If the request to pay above the BWC fee schedule is twice or more than the designated BWC fee schedule prior approval must be obtained by the MCO from BWC medical policy before submitting the adjustment. A note in V-3 is required regarding the MCO's case management that led to the need to pay above fee schedule to facilitate BWC medical policy consideration of approval.	X		X	Informational			
861	Payment made under guidelines of 1999 Hospital Cleanup Project.	This EOB should be attached to any adjustment requests for bills being paid as part of the March 1999 Hospital Bill Cleanup Project.			X	Adjustment			
862	Payment made-original bill received within two years of the date of service.	BWC requires that bills be submitted within two years of the date of service; if received on time, but denied in error or paid incorrectly, bill may be a candidate for adjusting. MCO must submit documentation of previous, timely submission when requesting adjustment.			X	Adjustment			
863	Line item adjusted to recover amount paid over fee schedule.	Reimbursement should not be made at a rate greater than fee schedule unless provider is non-certified and out of state. Payments made in error are corrected with this EOB.			X	Adjustment			
864	Adjusted to charge to correct risk number.	If the incorrect risk number is associated with a claim, bills may be charged to that risk in error. This EOB will be used when a bill is adjusted to the payment to be removed from the experience of the wrong risk and charged to the experience of the correct risk.			X	Adjustment			
865	Charged to rehab in error. Adjusting to charge services to the risk.	The MCO or BWC may find that services were charged to the Rehab Surplus Fund in error. If this occurs, the bill will be adjusted so that the expense will be correctly charged to the employer's experience.			X	Adjustment			

866	Payable per the guidelines of the 1999 changeover project.	MCO should attach this EOB to request adjustment to pay services for dates of service up to October 15, 1999 for out of statute claims that were changed from Lost Time to Medical Only as part of the 1999 changeover project.			X	Adjustment			
867	Automated Adjustment	For BWC use only. This EOB will be applied to bills that adjusted at BWC initiation through a mass, automated process.			X	Adjustment			
868	MCO is decertified but adjustment request was received prior to decertification date.	BWC will attach this EOB to any adjustment processed after an MCO's decertification date.			X	Adjustment			
869	Payment reissued. Original payment issued to Professional Comp Care, but provider alleges non-receipt of funds.	Following a review by BWC, this EOB will be attached to adjusted bills where payment was originally made to Professional Comp Care but PCC did not reimburse the provider.			X	Adjustment			
870	Payment voided as check has not been cashed within 6 months of issuance and MCO has been unable to contact provider.	MCOs are not permitted to retain BWC funds when a provider fails to cash a check issued for payment of medical bills. The MCO must take all possible steps to contact provider to determine reason for the failure to cash check (was it lost in the mail? Misplaced? Send to the wrong address?) If check remains uncashed for 6 months & provider has not responded, MCO should request void adjustment and attach this EOB. Adjustment request should include brief summary of efforts made to resolve without adjustment. NOTE: Bills that are voided will deny as duplicates if re-submitted, so please make certain that a void is the best resolution - do not request voids if MCO is going to reissue check.			X	Adjustment			
872	MCO has determined that services are related to SB 223 exposure.	When an MCO identifies a bill that appears to be related to SB 223, it should attach this EOB at the header level. This is particularly important in cases where the services billed are follow-ups to previous treatment.	X		X	Informational			
873	Line item EOB changed at the MCO's request.	If an MCO determines that it originally attached an incorrect or inaccurate EOB at the line level, it should use this EOB to document its request for a change of EOB.			X	Adjustment			
875	Item reversed following BWC Fraud Investigation recovery	Only used on BWC initiated adjustments, where BWC due to unusual circumstances has directly recovered funds from a provider. This EOB will be used to identify recoveries that were collected as a result of a special investigation by BWC's Special Investigation Unit. MCOs may not use this EOB on adjustment requests as it is for BWC use only.			X	Adjustment			
876	Payment above fee schedule to an in-state provider has been approved by BWC.	When an MCO believes that unusual circumstances justify payment above the BWC fee schedule to an in-state provider, it must contact BWC's Medical Policy department to discuss the matter. This discussion should take place before the bill is submitted as this is NOT an override EOB and will not result in automatic payment at the higher rate. Contacting Medical Policy before the bill is submitted will allow BWC to take steps to ensure correct reimbursement on initial submission (approval will be documented by email to the MCO and Medical Billing & Adjustments). If approval is not sought until after a bill has been paid at the lower rate, the MCO must include this EOB on the adjustment request and provide documentation of BWC's approval. Adjustment requests received without such documentation will not be processed until Medical Billing and Adjustments has determined that the requested payment has been authorized by BWC.	X			Informational			
877	Payment is being made in a disallowed claim for testing or other services due to alleged anthrax exposure (2001 Anthrax Policy).	Due to the anthrax threat in late 2001, BWC made a decision to break with normal policy and reimburse for testing for an alleged exposure. BWC will notify the assigned MCO of any affected claim that is disallowed but eligible for bill payment. If bills are received by the MCO for these claims, the MCO should price the bill at 0.00, attach EOB 256 and notify BWC of bill submission via email to HPPSSU@bwc.state.oh.us. Following a review of the bill(s), if approved for payment BWC will attach EOB 877 and release payment to MCO.			X	Adjustment			
878	2003 Prosthetic Project - charge to Surplus Fund.	This EOB is used only by BWC on adjustment of prosthetic bills that were incorrectly charged to the employer. This clean up project took place in April 2003.			X	Adjustment			
879	Payment is being made in a disallowed claim for testing or other services due to alleged exposure. (SB223)	This EOB is used to identify payments made for alleged exposure claims per Senate Bill 223.			X	Informational			
880	MCO verified that this hospital service is not a duplicate and is payable under BWC policies and procedures.	The MCO, in requesting the adjustment and attaching the EOB 880, is verifying that it has received and reviewed the appropriate bills, medical documentation, reports, and other pertinent documentation to support the payment of the services billed.			X	Adjustment			
881	MCO verified that this x-ray is not a duplicate and is payable under BWC policies and procedures.	The MCO, in requesting the adjustment and attaching the EOB 881, is verifying that it has received and reviewed the appropriate bills, medical documentation, reports, and other pertinent documentation to support the payment of the services billed.			X	Adjustment			
882	MCO verified that this Evaluation/Management code is not a duplicate and is payable under BWC policies and procedures.	The MCO, in requesting the adjustment and attaching the EOB 882, is verifying that it has received and reviewed the appropriate bills, medical documentation, reports, and other pertinent documentation to support the payment of the services billed.			X	Adjustment			

883	MCO verified that this physical therapy code is not a duplicate and is payable under BWC policies and procedures.	The MCO, in requesting the adjustment and attaching EOB 883, is verifying that it has received and reviewed the appropriate bills, medical documentation, reports, and other pertinent documentation to support the payment of the services billed.			X	Adjustment			
884	Data element changed to comply with current BWC requirements.	MCOs are expected to ensure that a bill meets current BWC billing requirements when submitting bills and prior to requesting an adjustment. If the bill contains information that is no longer acceptable, the MCO must document its modification of the bill or must authorize BWC to change the information by via adjustment with this EOB. For example, if submitting a bill or requesting an adjustment of a bill that contains a 1-digit place of service code, the MCO must provide the correct 2-digit place of service code and attach this EOB.	X		X	Informational			
885	MCO verified that this rehabilitation/other service is not a duplicate and is payable under BWC policies and procedures.	There will be occasions when a bill for rehabilitation services (or other service not covered by EOBs 880 - 883) appears to be a duplicate of another bill, but is actually a legitimate bill for similar services. For example, if both a Job Placement Specialist and a Case Manager travel on the same date, one of their bills, although valid, will deny as a duplicate. It will be the MCO's responsibility to review its documentation, verify that the services are not duplicates and request an adjustment with this EOB.			X	Adjustment			
886	Payment made for different level of inpatient care in the same hospital room.	MCO should use this EOB to authorize adjustments to pay inpatient accommodation codes that deny as duplicates but that actually represent a different level of care. The denied line should not be bundled.			X	Adjustment			
888	BWC Recovery Adjustment	Only used on BWC initiated adjustments, where BWC due to unusual circumstances has directly recovered funds from a provider. MCOs may not use this EOB on adjustment requests as it is for BWC use only.			X	Adjustment			
889	Payment is being made pursuant to the hospital fee schedule lawsuit settlement.	Attached by BWC to bills that are part of the lawsuit settlement.			X	Informational			
890	Item reversed following SI Dept recovery	Only used on BWC initiated adjustments, where BWC due to unusual circumstances has directly recovered funds from a provider. This EOB will be used to identify recoveries that were collected as a result of a recoveries initiated by BWC's Self Insured Department. MCOs may not use this EOB on adjustment requests as it is for BWC use only.			X	Adjustment			
891	BWC Recovery of Overpaid Medical - Item adjusted due to billing error by BWC Preferred Vendor	Only used on BWC initiated adjustments, This EOB will be used if the adjustment is due to a situation where an overpayment was made due to a billing error by a BWC preferred vendor, and BWC recovered the overpayment directly from the vendor. MCOs may not use this EOB on adjustment requests as it is for BWC use only.			X	Adjustment			
892	BWC Recovery of Overpaid Medical - Provider overpayment collected by BWC MCO Audit	Only used on BWC initiated adjustments, where BWC due to unusual circumstances has directly recovered funds from a provider. This EOB will be used when monies are directly recovered from a provider following an accepted referral to the MCO Audit Team for BWC intervention in the overpayment recovery process. MCOs may not use this EOB as it is for BWC use only.			X	Adjustment			
893	BWC Recovery of Overpaid Medical - BWC Hospital Overpayment Recovery Vendor	Only used on BWC initiated adjustments, where BWC due to unusual circumstances has directly recovered funds from a provider. This EOB will be used when monies are directly recovered from a provider by the BWC Hospital Overpayment Recovery Vendor. MCOs may not use this EOB as it is for BWC use only.			X	Adjustment			
894	Partial recovery of overpaid medical	This EOB should be included on any adjustment requests where the MCO has not been able to collect the entire amount overpaid to the provider for more than 90 days after an initial payment was recovered. Other EOBs explaining the cause of the overpayment should be included as well.			X	Adjustment			12/15/2010
895	BWC recovery - Paradigm, catastrophic claim vendor.	Used by BWC to document recovery adjustments where Paradigm has reimbursed BWC for bills it is covering under contract.			X	Adjustment	Added	This is a new EOB.	12/1/2013
897	MCO error in processing, MCO initiated adjustment.	Used by BWC to document adjustments resulting from errors in MCO processing.			X	Adjustment	Added	This is a new EOB.	12/1/2013
899	Item adjusted - BWC Recovery	Only used on BWC initiated adjustments, where BWC due to unusual circumstances has directly recovered funds from a provider. This EOB accompanies the payment item that offsets the combined negative effect of the reversed and new benefit line items. MCOs may not use this EOB on adjustment requests as it is for BWC use only.			X	Adjustment			
937	Payment is denied as records indicate that related services have previously been paid or are in process.	According to BWC records related services have previously been paid or are in process. Payment is denied.	X		X	Denial Code			
938	Payment is denied as this MCO bill document number already exists.	This network invoice number has already been received on another bill from this MCO. The network invoice number is the MCO's unique document number that identifies a specific bill.		X		Reject Code			
939	Network invoice number is missing.	There is no network invoice number associated with this bill.		X		Reject Code			
950	Payment is denied as the employer is a self-insured employer.	No longer in use			X	Obsolete	Changed	Change to document that BWC no longer uses this EOB.	10/10/2013

951	Payment is denied as this is a federally-funded claim. Please contact the assigned customer service specialist.	This error code will be used if a bill is submitted for Marine Industry Fund and Pneumoconiosis Fund claims governed by federal law. These claims are solely administered by BWC.		X		Reject Code			
967	No payment has been made as there were no charges listed or your total charges did not match the sum of the line item charges.	Total charge field has a zero amount or an amount that does not match the actual sum of the charges that were billed.		X		Reject Code			
968	BWC ID ADDED AFTER SPECIAL HANDLING OF NPI-ONLY BILL	If the bill comes into the MCO with no BWC ID, but with an NPI (or with an NPI with Taxonomy), but the MCO cannot identify the provider, the MCO should include this EOB if the provider supplies the MCO with the BWC ID upon request.	X		X	Informational			
969	PAYMENT IS DENIED AS THE PAY-TO PROVIDER DOES NOT HAVE A TAX ID ON FILE WITH BWC.	Payment is being denied because the pay-to provider on the bill does not have a tax identifier enrolled. Provider must contact provider Enrollment if they are to be paid.			X	Denial Code			
970	PAY-TO NPI CROSSWALK SUCCESS-NPI ONLY.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The pay-to provider number has the tax id embedded in the first 9 digits, will be included on the 835 remittance advice as well as the successfully cross walked NPI.			X	Informational			
971	PAY-TO NPI CROSSWALK SUCCESS-NPI/TAXONOMY ONLY.	The NPI and Taxonomy were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The pay-to provider number has the tax id embedded in the first 9 digits, will be included on the 835 remittance advice as well as the successfully cross walked NPI.			X	Informational			
972	PAY-TO NPI CROSSWALK SUCCESS-NPI/TAXONOMY/ZIP ONLY.	The NPI, Taxonomy and Physical Location ZIP were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The pay-to provider number has the tax id embedded in the first 9 digits, will be included on the 835 remittance advice as well as the successfully cross walked NPI.			X	Informational			
973	PAY-TO NPI CROSSWALK SUCCESS-NPI/ZIP ONLY.	The NPI and Physical Location ZIP were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The pay-to provider number has the tax id embedded in the first 9 digits, will be included on the 835 remittance advice as well as the successfully cross walked NPI.			X	Informational			
974	SERVICING NPI CROSSWALK SUCCESS-NPI ONLY.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill and will not be returned on the 835. The successfully cross walked NPI will be the only servicing provider identifier on the 835 remittance.			X	Informational			
975	SERVICING NPI CROSSWALK SUCCESS-NPI/TAXONOMY ONLY.	The NPI and Taxonomy were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill and will not be returned on the 835. The successfully cross walked NPI will be the only servicing provider identifier on the 835 remittance.			X	Informational			
976	SERVICING NPI CROSSWALK SUCCESS-NPI/TAXONOMY/ZIP ONLY.	The NPI, Taxonomy and Physical Location ZIP were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill and will not be returned on the 835. The successfully cross walked NPI will be the only servicing provider identifier on the 835 remittance.			X	Informational			
977	SERVICING NPI CROSSWALK SUCCESS-NPI/ZIP ONLY.	The NPI and Physical Location ZIP were submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill and will not be returned on the 835. The successfully cross walked NPI will be the only servicing provider identifier on the 835 remittance.			X	Informational			
978	ATTENDING NPI CROSSWALK SUCCESS.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The Attending Physician NPI is not sent back on the 835 (only servicing and pay-to provider identifiers are currently included in the 835 remittance), but this informational EOB is sent to communicate the successful cross walk of the Attending Physician.			X	Informational			
979	OTHER PHYSICIAN NPI CROSSWALK SUCCESS.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The Other Physician NPI is not sent back on the 835 (only servicing and pay-to provider identifiers are currently included in the 835 remittance), but this informational EOB is sent to communicate the successful cross walk of the Other Physician.			X	Informational			
980	OPERATING PHYSICIAN NPI CROSSWALK SUCCESS.	The NPI was submitted and used to cross walk to a single BWC eligibility record (11-digit BWC ID). The BWC ID was not submitted on the bill. The Operating Physician NPI is not sent back on the 835 (only servicing and pay-to provider identifiers are currently included in the 835 remittance), but this informational EOB is sent to communicate the successful cross walk of the Operating Physician.			X	Informational			
981	BILL PROCESSED USING BWC ID. OPERATING PHYSICIAN NPI BILLED NOT ENROLLED.	The BWC ID and the NPI are on the bill. The bill is processed using the BWC ID but the NPI that is on the bill has not been enrolled with BWC.			X	Informational			
982	BILL PROCESSED USING BWC ID. OPERATING PHYSICIAN NPI NOT BILLED BUT ENROLLED.	The BWC ID is on the bill. There is no NPI on the bill, and the bill is processed using the BWC ID. This EOB is informational only to let the provider know that there is an NPI in the provider file. While providers may enroll their NPI with BWC, providers are not required to use NPI in BWC billing.			X	Informational			

983	BILL PROCESSED USING BWC ID. OPERATING PHYSICIAN NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The BWC ID is on the bill. The NPI information on the bill matches the NPI information in the provider file data.			X	Informational			
984	BILL PROCESSED USING BWC ID. OPERATING PHYSICIAN NPI BILL CONFLICTS WITH NPI ENROLLED.	The BWC ID and the NPI are on the bill. The BWC ID is used to process the bill. The BWC ID on the bill conflicts with the provider file data indicating a problem with either the enrollment or the billing use of NPI.			X	Informational			
985	OPERATING PHYSICIAN NPI INFORMATION BILLED MATCHES NPI INFORMATION ENROLLED.	The NPI information on the bill matches the NPI information in the provider file data.			X	Informational			
989	Payment is denied as the claim number was omitted from the bill. Please resubmit the invoice with the appropriate claim number.	The claim number field was left blank. Bill will need to be resubmitted with a valid BWC issued claim number.		X		Reject Code			