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EDI IMPLEMENTATION DOCUMENTATION
EXPLANATION OF BENEFITS CODES

Health Partnership Program
for
Ohio Bureau of Workers' Compensation and Managed Care Organizations

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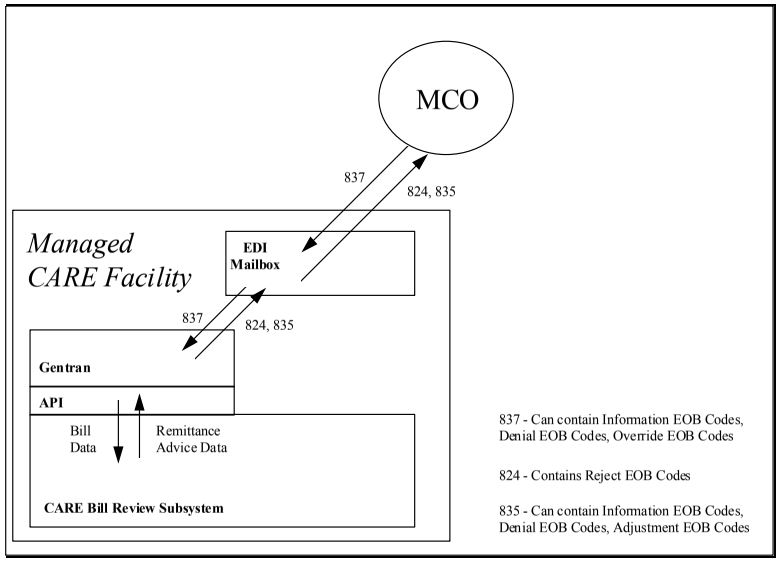
Explanation of Benefit Codes (EOBs) in the Health Partnership Program

Managed Care Organizations (MCOs) submit priced bills to BWC for review of compensability and for final pricing and payment. In most cases, the MCO is required to submit denied line items or bills for BWC's records.

The 837 transaction set is the EDI format MCOs are required to use for billing BWC. The 824 transaction set is the EDI format MCOs will receive from BWC when the data sent does not meet BWC's requirements. Bills rejected on the 824 have not been processed in the Managed CARE System and must be re-submitted. The 835 transaction set indicates the results of bill processing. It contains detail on any bills paid, adjusted or denied by BWC.

The following diagram depicts the data flow between the MCO and BWC's bill review subsystem:



This document outlines the way MCOs are expected to use EOBs on the 837 transaction set and the way BWC will use EOBs on the 824 and 835 transactions. EOB codes can be used at the header level if they apply to claim or provider information on the bill. EOBs with criteria that relate to line item detail must be associated with the specific line item to which they apply. Questions about correct EOB use should be directed to BWC Medical Policy at 614-466-0048.

The **BWC EOB Code Table** contains all EOBs recognized by BWC.

MCO's Use of EOB Codes on 837 Transaction

When an MCO submits denied bills or line items to BWC, it must use BWC's EOB codes to indicate reasons for denial. EOB codes can also be used to override BWC policy, to provide general pricing and clinical editing information, and to indicate reasons for adjustment requests.

837 Denial Codes (from the MCO to BWC)

BWC requires MCOs to submit bills once a claim has been determined. Bills are considered payable only if the claim is in an allowed status. While the claim is being investigated, MCOs are expected to notify providers that bills have been received and why they have not been submitted to BWC. The BWC EOB Code Table includes a column designating the transaction set where specific EOB codes can be used. EOB codes which are designated for use on the 837 must be used when the MCO receives a bill meeting the EOB criteria. Bills should only be rejected without processing if they meet the reject criteria outlined in Chapter 8 of the MCO Policy Reference Guide.

MCOs are required to submit bills or line items to BWC if they have been denied for any of the following reasons:

Compensability: If the condition treated is not allowed in the claim and there are no circumstances that make BWC liable for the services, the MCO may deny the provider's bill or line item. The MCO must submit the denied bill record on the 837 transaction to BWC. The 837 must contain appropriate EOB codes and MCO-priced amounts of $0.00. For example, if the MCO receives a bill for a condition unrelated to the claim, the detail of a line item might contain the following elements:

Line Number	Date of Service	Place of Service	ICD-9 Code	Procedure Code	Modifier	Provider Charges	MCO Priced Amount	EOB
03	031297	11	**722.10**	63030	62	5000.00	0.00	276

Coverage of services: If the MCO denies services because they are not normally covered in workers' compensation cases, the 837 transaction must be submitted to BWC. It must contain appropriate EOB codes and MCO-priced amounts of $0.00. These bills include those denied because the service is not routinely covered under the Ohio Workers' Compensation program.

Utilization management: Any services which have been denied by the MCO because they do not conform to MCO-specific guidelines must be submitted on the 837 transaction to BWC. A number of the EOBs in the **BWC EOB Code Table** can be used for this purpose. BWC will create additional EOBs and make them available to all MCOs as necessary.

837 Information Codes (from the MCO to BWC)

Some codes are used to relay information to BWC. Most of these codes will indicate that clinical editing has been applied to a bill.

Multiple procedures:
MCOs are required to use information codes on bills for multiple procedures in the 10000-69999 CPT code range. BWC policy is to reimburse no more than 5 procedures from this range on a single date of service. BWC requires that the MCO indicate the ranking it has used in pricing multiple procedures. Codes 758, 759, 760, 761, and 762 should be used at the line-item level to indicate the first through fifth procedures priced. In rare cases, it is clinically justifiable to reimburse more than five procedures on a single date of service. In these situations, the MCO should either notify their billing contact to request special processing or request an adjustment of the bill.

So, for example, if a provider bills multiple surgical procedures for one date of service, the MCO's priced line item detail would look like the following:

Line Number	Date of Service	Place of Service	ICD-9 Code	Procedure Code	Provider Charges	MCO Priced Amount	EOB
01	031297	11	955.6	26356	1200.00	990.00	**759**
02	031297	11	955.6	20550	100.00	0.00	**518**
03	031297	11	955.6	64830	500.00	0.00	**113**
04	031297	11	955.6	64831	1000.00	450.00	**758**
05	031297	11	955.6	64832	600.00	200.00	**762**
06	031297	11	955.6	64837	900.00	400.00	**760**
07	031297	11	955.6	64722	900.00	325.00	**761**

EOB 113 should be used to indicate that no reimbursement is being made because more than 5 procedures in the 10000-69999 range were billed.

EOB 518 may be used with all providers to indicate that services are denied because they should be part of the provider's global fee for a service.

Clinical Editing

BWC has developed a number of EOBs to enable MCOs to indicate procedures where clinical edits have been applied. In submitting bills where these edits have been applied, MCOs should include all original line items billed by the provider. For example, if a provider bills the following charges, the MCO might determine that a more comprehensive code would cover all services:

Provider's Bill:

Line Number	Date of Service	Place of Service	ICD-9 Code	Procedure Code	Charges
01	031297	11	847.2	72100	300.00
02	031297	11	847.0	72040	500.00
03	031297	11	847.1	72070	100.00

The MCO would submit the following bill on the 837 transaction set to BWC:

MCO's edited bill:

Line Number	Date of Service	Place of Service	ICD-9 Code	Procedure Code	Provider Charges	MCO Priced Amount	EOB
01	031297	11	847.2	72100	0.00	0.00	**764**
02	031297	11	847.0	72040	0.00	0.00	**764**
03	031297	11	847.1	72070	0.00	0.00	**764**
04	031297	11	847.1	72010	900.	93.04	**765**

If the MCO reviews a bill containing a CPT-4 unlisted procedure code and finds that the provider's documentation indicates that the service provided is one for which a specific code exists, then the bill could be edited and submitted to BWC as follows:

Line Number	Date of Service	Place of Service	ICD-9 Code	Procedure Code	Provider Charges	MCO Priced Amount	EOB
01	031297	11	847.2	97139	50.00	0.00	**767**
02	031297	11	847.2	**97010**	50.00	15.53	**768**

If the documentation is not sufficient to determine the appropriate billing code, an MCO might choose to deny the bill and submit the denied bill on the 837 transaction to BWC using denial code 348 with the line item detail.

837 Override Codes (from the MCO to BWC)

Some EOB codes can be used by the MCO to override specific BWC policies; they can never be used to force payment in cases of invalid data or in cases where there is a law or rule prohibiting payment by BWC.

Examples of valid overrides:

- The procedure code billed is valid on the date of service, but is not normally covered under the Ohio Workers' Compensation program. EOB 752 can be used to authorize payment if the MCO believes this code is appropriate for the services rendered and the services are related to the claim.
- The diagnosis code billed is not addressed in the claim. It is clear from the documentation that the condition is related to the claim. Further information is available in the MCO Policy Reference Guide. Override EOB code 776 can be used in this instance. It is not appropriate to ask a provider to change the diagnosis billed except in cases of typographical errors.
- The date of service on the bill is 1/1/1999 or later and the provider is an in-state, non-certified provider. The MCO may authorize reimbursement to a non-certified provider for initial and emergency treatment and where there are special circumstances. EOBs 749 (initial/emergency treatment) and 756 (special circumstances) are used to authorize payment to a non-certified provider under these circumstances.

Examples of situations where no override is possible:

- The servicing or pay-to provider number is not a valid, 11-digit BWC provider number. BWC cannot reimburse for services rendered by a provider who has not been enrolled by BWC.
- The procedure code billed is not a code BWC recognizes as valid. Either the code is not valid on the date of service or the code is not a valid CPT-4, HCPCS or revenue center code.
- The ICD-9 diagnosis code billed does not exist.

Adjustment Codes (from the MCO to BWC)

Adjustment EOBs in the 800-899 range and will not be accepted on the 837 transaction. They should only be submitted on requests for adjustment. Details about when and how to request adjustments are included in BWC's Adjustment Request Documentation.

BWC's Use of EOB Codes

BWC uses EOBs as reject codes on the 824 transaction, and as denial or information codes on the 835 transaction.

824 Reject Codes (from BWC to the MCO)

In the **BWC EOB Code Table**, many codes are identified as reject codes to be used by BWC on any 824 transaction set generated as a response to an 837 transaction. These will be used when a bill does not meet the data requirements for BWC to accurately review the bill. In these cases, the entire bill will be rejected and a new 837 transaction will be required.

835 Denial Codes (from BWC to the MCO)

There are codes that will be used as denial codes in the 835 transaction on any line items or bills which BWC cannot reimburse. BWC will deny bills or line items when they do not meet compensability requirements, when they are exact duplicates of another paid bill, or when non-covered services are billed without an override EOB code.

835 Information Codes (from BWC to the MCO)

In some instances, EOB codes will be used on paid line items on the 835 transaction as a message to the MCO. For example, if an MCO prices a non-panel bill at panel prices, EOB 746 will appear on the appropriate line item(s).

BWC Explanation of Benefits Table

The following table contains all explanation of benefits (EOB) codes currently used by BWC and which may be used by BWC and MCOs as part of the Health Partnership Program.

Changes since the last revision: New or revised EOBs are italicized.

Column Heading Definitions:

EOB: Numeric code assigned by BWC. Managed Care Organizations must use this code for any EOB submitted on the 837 EDI transaction to BWC.

EOB description: Brief explanation of the EOB code.

Criteria: Criteria used in applying the EOB code. This explanation includes references to BWC-specific business processes as well as the specific data element combinations which may trigger the EOB. It includes instructions on when the MCO must use a specific EOB.

837/824/835: Indicates the EDI transaction set where the code will be used. The MCO may use any of the EOBs listed in this document in its bill review process with providers. If an MCO denies a bill for any reason corresponding to an EOB designated as eligible to appear on the 837 transaction, the bill must be submitted to BWC. If there is no "X" in these columns, this EOB is one that was used by BWC prior to HPP and the EOB is in this list for the MCO's information only.

Code Type: Indicates whether the code is considered a denial, reject, information, override or adjustment code.

EOB	EOB Description	Criteria	837*	824	835	Code Type
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 only. 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.				Reject Code
030	Payment is denied as no modifier was billed with this anesthesia procedure code	All anesthesia procedure codes require a modifier.			X	Denial Code
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
090	Payment is denied as, except for servicing provider, this is a duplicate of a previously paid service.	Exact duplicate except: servicing provider.			X	Denial Code
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.			X	Denial Code

* Bills containing codes indicated in this column must be submitted to BWC

EOB	EOB Description	Criteria	837*	824	835	Code Type
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. The following data elements match those on another previously paid bill or another bill currently in process: MCO ID, servicing provider, SSN, date of service, procedure, billed amount, and units of service.			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.			X	Denial Code
101	Payment is denied as this bill is an exact duplicate of another previously paid bill or another bill being processed.	Exact duplicate except 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	Denial Code
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 an 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	Payment is denied because this procedure exceeds the BWC limit for procedures (CPT 10000-69999) per date of service.	More than 5 procedures (10000-69999) have been billed for one date of service.	X		X	Denial Code
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 do not equal 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

* Bills containing codes indicated in this column must be submitted to BWC

EOB	EOB Description	Criteria	837*	824	835	Code Type
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 guidelies. 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 was not received within 2 years of the date of service as required by statute.	The MCO received date was not within two years of the date of service.	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 edit 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.				N/A
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 he 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		Reject Code

* Bills containing codes indicated in this column must be submitted to BWC

EOB	EOB Description	Criteria	837*	824	835	Code Type
137	(This EOB has been removed.) The occurrence dates are missing.	The occurrence dates are missing.				
140	(This EOB has been removed.) The value code is invalid.	The value code on a hospital bill is invalid.				N/A
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		Reject Code
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		Reject Code
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
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	Payment is denied as the admission date and the service date conflict.	The admission date on an inpatient hospital bill is after the first covered date.		X		Reject Code

* Bills containing codes indicated in this column must be submitted to BWC

EOB	EOB Description	Criteria	837*	824	835	Code Type
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.	This EOB code is used to enforce BWC coding requirements. It is generated when an ICD-9-CM "E" diagnosis code is used on a non-facility bill. BWC never accepts "E" diagnosis codes as the primary diagnosis.		X		Reject Code
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
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 edit has been removed.) Payment is denied as the date of surgery is missing.	Date of surgery is missing from theUB-92 block 80				N/A
199	(This edit has been removed.) ICD-9 procedure code is missing.	ICD-9 procedure code is missing from the UB-92 block 80				N/A
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 nonfacility 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 to provider

* Bills containing codes indicated in this column must be submitted to BWC

EOB	EOB Description	Criteria	837*	824	835	Code Type
210	BWC cannot reimburse these services as this claim is part of the $1,000 Medical-Only Program. Submit medical bills to the injured worker's employer.	The claim is part of the $1,000.Medical-Only Program ($1K Program). Employers who participate in this program are responsible for all bills in eligible claims until the $1,000 limit has been met. The employer notifies BWC when the limit is met and further medical treatment is managed and billed like that for any other claim. The employer has the option of removing a claim from this program at any time, but is responsible for the first $1,000 in bills during the time that the claim was part of the $1K program.	X		X	Denial Code
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
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 received after a claim is settled. Possible adjustments must be handled through the Bill Resolution process.	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

* Bills containing codes indicated in this column must be submitted to BWC

EOB	EOB Description	Criteria	837*	824	835	Code Type
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
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			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 bill these services with override EOB 776 for the charges to be reimbursed.	X		X	Denial Code

EOB	EOB Description	Criteria	837*	824	835	Code Type
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 status 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 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 bill is prior to the date of injury of an OD claim. This EOB cannot be overridden.	X		X	Denial Code
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 <u>after</u> 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
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

* Bills containing codes indicated in this column must be submitted to BWC

EOB	EOB Description	Criteria	837*	824	835	Code Type
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 nonfacility bill.	Hospital providers cannot bill on the nonfacility form.		X		Reject Code
343	Payment is denied as the diagnosis code billed is not eligible as a claim allowance.	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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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 indicate 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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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.	X		X	Denial Code
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 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			Information
379	Payment is denied as this procedure or service is not eligible for reimbursement to an ambulatory surgical center.	There is no ASC group associated with this procedure code.	X		X	Denial Code
380	Payment is denied as the anesthesia modifier is not approptiate 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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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	Denial Code
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
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 normally covered. The MCO always has the option of authorizing a non-covered service. BWC will reimburse such a service only if override EOB 752 is used.	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 rejectionof the 837with this EOB.		X		Reject Code
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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

EOB	EOB Description	Criteria	837*	824	835	Code Type
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	Denial Code

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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	Denial Code
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
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
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
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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			Information
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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			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			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*	*Denial Code*
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.	X		X	Denial Code

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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 id denied as these physical medicine/OMT/CMT services/visits exceed 10 in the initial time frame and have not been authorized.	The presumptive approval policy allows up to 10 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 10 physical medicine visits in the initial 60 day period but has not obtained prior authorization for them, payment will be denied by the MCO.	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

EOB	EOB Description	Criteria	837*	824	835	Code Type
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 pending, non-payable status in this claim.*	*This EOB will be sent when the billed diagnosis code is in alleged, allow/appeal, disallow/appeal or hearing status. These statuses cannot be overridden.*			*X*	*Denial Code*

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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*
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
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			Information
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			Information
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			Information
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			Information

* Bills containing codes indicated in this column must be submitted to BWC

EOB	EOB Description	Criteria	837*	824	835	Code Type
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 $1000 program. This item has been priced to reflect partial payment by the employer.	Employer has reimbursed the first $1000 of injured workers claim. BWC is responsible for additional reimbursement.	X			Information
710	This bill has been adjusted following retrospective review.	After further review, this bill has been adjusted.			X	Information
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.	Programming for this EOB is in development. Use 776 in the interim.	X			Override
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.	Programming for this EOB is in development. Use 776 in the interim.	X			Override
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			Information
714	This bill has been priced according to this MCO's pricing policies.	This code has been created at MCO request.	X			Information
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	Information
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 priced. 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	Information
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			Override

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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			Information
752	Payment has been made for a BWC non-covered service.	This override EOB must be used to indicate that a BWC non-covered service has been reimbursed. The MCO is required to use this override EOB at the line-item level when non-covered services are authorized. If the MCO believes a routinely non-covered service is appropriate, it must be used at the line-item level. If this EOB is not used, BWC will deny reimbursement.	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			Information
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			Information
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			Information

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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			Information
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			Information
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			Information
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			Information
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			Information
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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			Information
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			Information
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	Information
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			Information
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
777	Payment is being made for an invalid/non-specific ICD-9 diagnosis code due to special circumstances.	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	Adjustment
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	Informational until March 2004
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 priced according to BWC guidelines.			X	Information
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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
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
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
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	Denial
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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, it must contact its BWC billing representative before submitting the bill. This EOB must be attached to the bill by the MCO when the bill is submitted. The MCO can use this EOB on adjustment requests as well but should still contact its billing representative first.	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 will 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 adjusted so that the expense will be correctly charged to the employer's experience.			X	Adjustment

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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*			*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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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 prothestic 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

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EOB	EOB Description	Criteria	837*	824	835	Code Type
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

EOB	EOB Description	Criteria	837*	824	835	Code Type
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 rehabiliation 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 a 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
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	Denial Code
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
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

* Bills containing codes indicated in this column must be submitted to BWC

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