Explanation of Benefits (EOB) Numbers

Providers can use this Quick Reference Guide to find additional steps and resources to review and rectify EOB bill denials.

How to use the reference guide:

1) On the next page, select an EOB Number link to be redirected to the specific EOB information page within this guide. The specific EOB information page shows:
   - The EOB description seen on the OWCP Remittance Voucher (RV)
   - Additional steps to clarify the EOB verbiage along with links to tips, tutorials, and guides
2) Select the Return to EOB List link at the bottom right corner of the page to return to the EOB Number menu.

Explanation of Benefits (EOB) Numbers

Select an EOB Number below to navigate to the page to review the description and additional steps that need to be taken.

EOB Numbers							
20530	20531	20532	20533	20731	21487	21731	22733
30275	30598	31589	31598	40363	50301	50309	50424
60340	60342	60431	60448	60923	61172	70863	70865
80024	80070	80074	80101	80102	80103	80105	80906
81070	90125	90128	90138	90336	90528	90542	90671
90925	91125	92125	00079	00173	00174	00176	00183
00184	00188	00213	00214	00236	00253	00323	00324
00344	00498	00740	00741	00742	00743	00744	00745
80010	80015	80017	80021	80031	80032	80036	80061
80062	80081	80083	80084	80085	80088	80089	80090
80415	90906	70910	20650	60915	40117	50408	60217
60961	80416	80417	80418	80419	80420	80058	80059
80060	90132	90918	90920	90922	90160	80003	80004

Explanation of Benefits (EOB) Numbers, Continued

Select an EOB Number below to navigate to the page to review the description and additional steps that need to be taken.

EOB Numbers							
80005	81005	80007	80008	80011	80013	80016	80018
80019	80020	80421	80422	80423	80424	80425	80426
81044	90971	80080	80904	80905	80907	80908	80909
80910	80911	80912	80757	81757	82757	83757	84757
85757	90965	90966	91966	60148	60163	60195	60197
60218	60239	60240	60241	60243	60244	60245	60258
60280	60324	60347	60451	60454	60455	60456	60550
81021	80151	80152	80079	70861	40439	81019	81061
00247	00642	00803	00823	00824	00831	00832	00835
90569	90595	90916	90917	90930	91015	91016	91017
91018	91020	91022	91023	50295	50297	51297	50303
51303	50294	20733	21733	30250	30271	30401	30538
30589	30597	30652	31652	30655	31655	40109	40111

Explanation of Benefits (EOB) Numbers, Continued

Select an EOB Number below to navigate to the page to review the description and additional steps that need to be taken.

EOB Numbers							
40114	41114	40140	40207	40305	40905	50261	50300
50306	50320	50328	50405	50447	51447	50524	50610
50612	50901	70911	80071	80072	80073	80075	80077
80078	20487	90112	20919	30219	30265	30557	31557
30403	30534	60432	60434	60435	60551	60654	60821
60170	60323	60346	60437	60499	60522	60548	60554
60555	70209	70298	70307	90503	90504	90505	90506
90507	90508	90584	90681	90902	90942	90227	90255
90378	90387	90912	90970	90974			

Explanation of Benefits Number
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20530
EOB NUMBER

EOB DESCRIPTION

Precertification/authorization/notification absent.

ADDITIONAL STEPS

Prior authorization required for billed service and no valid authorization is on file for claimant.

Check that there is an authorization for all the procedures.

Check that the authorization was submitted prior to the DOS.

Authorizations may be submitted retroactively for services.

Refer to Provider Tips and FAQs for more information:

WCMBP Portal: Authorization Tips and corrections
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

20531

EOB NUMBER

EOB DESCRIPTION

Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.

ADDITIONAL STEPS

Authorization is on file for the claimant, but the authorization does not match the billing OWCP provider ID or the billing NPI does not match the NPI on file for the billing OWCP Provider ID.

Authorizations may be submitted retroactively for services.

Refer to Provider Tips and FAQs for more information:

WCMBP Portal: Authorization Tips and corrections
DCMWC Certificate of Medical Necessity FAQs

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Explanation of Benefits Number
Quick Reference Guide

20532
EOB NUMBER

EOB DESCRIPTION
Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the date(s) of service.

ADDITIONAL STEPS
Authorization is on file for the claimant and provider but not for the date of service being billed. Authorization request or correction must be submitted.

Authorizations may be submitted retroactively for services.

Refer to Provider Tips for more information:

WCMBP Portal: Authorization Tips and corrections
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

20533
EOB NUMBER

EOB DESCRIPTION
Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.

ADDITIONAL STEPS
Authorization is on file for the provider, claimant, and the date of service being billed, but not for the procedure code or the procedure code modifier. Authorization request or correction must be submitted.

Authorizations may be submitted retroactively for services.

Refer to Provider Tips and FAQs for more information:

WCMBP Portal: Authorization Tips and corrections
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

20731

EOB NUMBER

EOB DESCRIPTION

Precertification/notification/authorization/pre-treatment exceeded: The number of Days or Units of Service exceeds our acceptable maximum

ADDITIONAL STEPS

All authorized units have already been used. Submit a new authorization request or an authorization correction to request additional units.

Refer to Provider Tips and FAQs for more information:

WCMBP Portal: Authorization Tips and corrections
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

21487

EOB NUMBER

EOB DESCRIPTION

Precertification/authorization exceeded.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

Simple or minor CA-1 traumatic injuries with no work time lost may be covered under an administrative code to cover medical expenses up to $1500 or 180 days from the date of injury. If the amount exceeds the established threshold, the claimant's case goes to formal adjudication. Providers can submit supporting documentation to U.S. Department of Labor, OWCP/DFEC, PO Box 8300, London, KY 40742-8300. Refer to the DFEC Procedure Manual | U.S. Department of Labor (dol.gov) for more information.

Refer to the Division of Federal Employees' Compensation (DFEC) FAQs for more information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

21731
EOB NUMBER

EOB DESCRIPTION
Precertification/notification/authorization/pre-treatment exceeded.

ADDITIONAL STEPS
The authorized dollar amount has already been used. Submit an authorization request or an authorization correction to request additional dollars.

Refer to Provider Tips and FAQs for more information:

WCMBP Portal: Authorization Tips and corrections
DCMWC Certificate of Medical Necessity FAQs

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

22733
EOB NUMBER

EOB DESCRIPTION
Precertification/notification/authorization/pre-treatment exceeded: The number of days or units of service exceeds our acceptable maximum.

ADDITIONAL STEPS
The line-item units or dollar amount exceeds the authorized amount on file. Submit an authorization request or an authorization correction to request additional dollars.

Refer to Provider Tips for more information:

WCMBP Portal: Authorization Tips and corrections
DCMWC Certificate of Medical Necessity FAQs

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Explanation of Benefits Number
Quick Reference Guide

30275
EOB NUMBER

EOB DESCRIPTION
Patient has not met the required eligibility requirements.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The claimant is not eligible for benefits under the DCMWC program at this time. Log in to the WCMBP Portal to check the claimant's eligibility to ensure the claimant is eligible for the program. If the claimant is eligible for service under the program, resubmit for reconsideration.

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Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

30598

EOB NUMBER

EOB DESCRIPTION

Expenses incurred after coverage terminated.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

This case is denied for the dates of service. Log in to the WCMBP Portal to check the claimant's eligibility to ensure the claimant is eligible for the date of service. If the claimant is eligible for the date of service, resubmit the bill for reconsideration. Also, the claimant may contact their Claims Examiner (CE) for further assistance.

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Explanation of Benefits Number

Quick Reference Guide

31589

EOB NUMBER

EOB DESCRIPTION

The date of death precedes the date of service.

ADDITIONAL STEPS

The claimant has a date of death on file. The billed date of service is after the date of death. Log in to the WCMBP Portal to check the claimant's eligibility to ensure the claimant is eligible for the date of service. If the claimant is eligible for the date of service, resubmit the bill for reconsideration which can be done through DDE, EDI or Paper.

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Explanation of Benefits Number
Quick Reference Guide

31598
EOB NUMBER

EOB DESCRIPTION

Expenses incurred after coverage terminated: Patient ineligible for this service.

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC program.

The claimant is not eligible for benefits under the DCMWC program. Log in to the WCMBP Portal to check the claimant eligibility to ensure the claimant is eligible for the date of service that was submitted on the bill. If the claimant is eligible for the date of service. Resubmit for correction.

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Explanation of Benefits Number
Quick Reference Guide

40363
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Invalid combination of modifiers.

ADDITIONAL STEPS
The modifier appended to the billed procedure code is not payable with this procedure. Correct and resubmit.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule
(https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

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Explanation of Benefits Number
Quick Reference Guide

50301
EOB NUMBER

EOB DESCRIPTION

The procedure code is inconsistent with the provider type/specialty (taxonomy): This provider type/provider specialty may not bill this service.

ADDITIONAL STEPS

The provider type you have enrolled with is not authorized for this service. The Provider needs to revisit the billed code or review their enrollment file to reflect the correct provider type.

To update provider enrollment, refer to the Quick Reference Guide for more information:

Updating Provider Information (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50309
EOB NUMBER

EOB DESCRIPTION

This provider was not certified/eligible to be paid for this procedure/service on this date of service. The provider must update license information with the payer.

ADDITIONAL STEPS

The license on file for the billed provider number has expired. The provider must submit updated license or certification information to update. Once the license on file is updated, resubmit the bill for reconsideration.

To update provider enrollment, refer to the Quick Reference Guide for more information:

Updating Provider Information (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50424
EOB NUMBER

EOB DESCRIPTION
This provider was not certified/eligible to be paid for this procedure/service on this date of service.

ADDITIONAL STEPS
The provider number submitted on the bill is not active for the billed dates of service. The provider must submit the required documentation to reactivate their profile. Once your provider status becomes active, resubmit the bill for reconsideration.

To update provider enrollment, refer to the Quick Reference Guide for more information:

Updating Provider Information (dol.gov)

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Explanation of Benefits Number

Quick Reference Guide

60340

EOB NUMBER

EOB DESCRIPTION

This (these) diagnosis(es) is (are) not covered. Missing/incomplete/invalid principal diagnosis.

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC program.

The billed diagnosis is not payable under the DCMWC program. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the program and the claimant. If the diagnosis code is covered for the claimant and program, resubmit the bill for reconsideration.

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Explanation of Benefits Number

Quick Reference Guide

60342

EOB NUMBER

EOB DESCRIPTION

This (these) diagnosis(es) is (are) not covered: Missing/incomplete/invalid principal diagnosis.

ADDITIONAL STEPS

The billed diagnosis is not payable for the billed program. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the program and the claimant. If the diagnosis code is covered for the claimant and program, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

60431
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s). Not covered with this procedure.

ADDITIONAL STEPS
The billed procedure code is not a covered service. Log in to the WCMBP Portal to check the claimant's eligibility to ensure the procedure code is covered for the date of service and claimant. If the procedure code is covered for the date of service and claimant, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

60448
EOB NUMBER

EOB DESCRIPTION
This service/equipment/drug is not covered under the patient's current accepted condition.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billed Revenue Center Code (RCC) on the UB-04 institutional bill is not payable for the DCMWC program.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60923
EOB NUMBER

EOB DESCRIPTION
Diagnosis was invalid for the date(s) of service reported.

ADDITIONAL STEPS
The billed diagnosis is not covered for the service date. Log in to the WCMBP Portal to check the claimant's eligibility to ensure the diagnosis code is covered for the date of service and claimant. If the diagnosis code is covered for the date of service and claimant, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

61172
EOB NUMBER

EOB DESCRIPTION

Revenue code and procedure code do not match or is missing/incomplete/invalid. .

ADDITIONAL STEPS

The billed Revenue Center Code (RCC) on the UB-04 institutional bill requires a procedure code and the procedure code is missing or invalid for the corresponding RCC code.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule (https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

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Explanation of Benefits Number

Quick Reference Guide

70863

EOB NUMBER

EOB DESCRIPTION

Non-covered charge(s). Services not related to the specific incident/claim/accident/loss being reported.

ADDITIONAL STEPS

The billed diagnosis is not related to accepted conditions. If you disagree, submit medical documentation.

Refer to Provider Tips for more information:

Services for Accepted Conditions.pdf (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

70865
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s). Services not related to the specific incident/claim/accident/loss being reported.

ADDITIONAL STEPS
The billed procedure is not related to the accepted conditions on file for the claimant. If you disagree, submit medical documentation

Refer to Provider Tips for more information and details on how to submit medical documentation:

Services for Accepted Conditions.pdf (dol.gov)

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Explanation of Benefits Number
Quick Reference Guide

80024
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved /allowed within time period without support documentation.

ADDITIONAL STEPS
The provider may rebill with supporting medical documentation.

Refer to the following links for more information:

Bill Adjustment Void Tutorial (dol.gov)
Provider Tips – OWCP Appeals vs Adjustments (dol.gov)

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80070

EOB NUMBER

EOB DESCRIPTION

This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated: Add-on code cannot be billed by itself.

ADDITIONAL STEPS

This procedure code is used as an add-on to another procedure code and the base code was not billed with matching dates of service.

Refer to Correct Coding Initiative (CCI) guidance for further information.

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Explanation of Benefits Number

Quick Reference Guide

80074

EOB NUMBER

EOB DESCRIPTION

The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated: Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

ADDITIONAL STEPS

This procedure code is considered a component of another procedure billed for the same date.

Refer to Correct Coding Initiative (CCI) guidance for further information.

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Explanation of Benefits Number
Quick Reference Guide

80101
EOB NUMBER

EOB DESCRIPTION
Exact duplicate claim/service.

ADDITIONAL STEPS
This bill is a duplicate of a previously submitted bill. Bill inquiry and copies of previous Remittance Vouchers (RVs) are available for your reference.

Refer to Provider Tips for more information:

Viewing Bills on the Web Portal.pdf (dol.gov)

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Explanation of Benefits Number
Quick Reference Guide

80102
EOB NUMBER

EOB DESCRIPTION

Exact duplicate claim/service: Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.

ADDITIONAL STEPS

This bill is a probable duplicate, meaning that the line item posting the EOB is a probable match to another bill.

Bill inquiry and copies of previous Remittance Vouchers (RVs) are available for your reference.

Refer to Provider Tips for more information:

Viewing Bills on the Web Portal.pdf (dol.gov)

If an adjustment is required, refer to Provider Tips for more information:

Provider Tips – OWCP Appeals vs Adjustments (dol.gov)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80103
EOB NUMBER

EOB DESCRIPTION

Exact duplicate claim/service: Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.

ADDITIONAL STEPS

This bill is a possible duplicate, meaning that the line item posting the EOB is a possible match to another bill.

Bill inquiry and copies of previous Remittance Vouchers (RVs) are available for your reference.

Refer to Provider Tips for more information:

Viewing Bills on the Web Portal.pdf (dol.gov)

If an adjustment is required, refer to Provider Tips for more information:

Provider Tips – OWCP Appeals vs Adjustments (dol.gov)

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80105

EOB NUMBER

EOB DESCRIPTION

Exact duplicate claim/service: Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.

ADDITIONAL STEPS

This bill is a possible duplicate, meaning that the line item posting the EOB is a possible match to another bill.

Bill inquiry and copies of previous Remittance Vouchers (RVs) are available for your reference.

Refer to Provider Tips for more information:

Viewing Bills on the Web Portal.pdf (dol.gov)

If an adjustment is required, refer to Provider Tips for more information:

Provider Tips – OWCP Appeals vs Adjustments (dol.gov)

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Explanation of Benefits Number
Quick Reference Guide

80906
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Procedure code A6250 is limited to three (3) per six (6) months per claimant. If units are exceeded, the bill line denies.

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Explanation of Benefits Number
Quick Reference Guide

81070
EOB NUMBER

EOB DESCRIPTION
This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated: Add-on code cannot be billed by itself.

ADDITIONAL STEPS
Procedure code is an add-on code. The base procedure codes is not paid for the same date of service.

Refer to Correct Coding Initiative (CCI) guidance for further information.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

90125

EOB NUMBER

EOB DESCRIPTION

An attachment/other documentation is required to adjudicate this claim/service. Missing documentation: Nurse progress note is required with submission of home health care related services.

ADDITIONAL STEPS

Required attachments are missing from the submitted bill or do not match the billed claimant and date of service. Attachments must be signed by the caregiver along with the caregiver title.

Providers should correct and resubmit the bill.

Refer to the DEEOIC policy and procedure for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90128
EOB NUMBER

EOB DESCRIPTION
The time limit for filing has expired.

ADDITIONAL STEPS
Bill was submitted more than one year after the calendar year in which service was provided or in which claim was first accepted.

Providers can request an adjustment and submit proof of timely filing. Proof of timely filing can include a denied TCN that was submitted timely, copy of a bill RTP (returned to provider) letter, or a remittance voucher documenting timely filing.

Refer to the following links for more information:

Bill Adjustment Void Tutorial (dol.gov)

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

90138

EOB NUMBER

EOB DESCRIPTION

Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid type of bill.

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC program.

Certain facility services are not payable based on the type of bill submitted on the UB-04 institutional bill for the DCMWC program.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90336
EOB NUMBER

EOB DESCRIPTION
An attachment/other documentation is required to adjudicate this claim/service: Missing invoice.

ADDITIONAL STEPS
This billed line item denied because proof of purchase invoice from the manufacturer was not submitted.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

90528

EOB NUMBER

EOB DESCRIPTION

Claim/service lacks information or has submission/billing error(s): Billed services with submitted diagnosis or condition is not covered by the DCMWC.

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC program.

The billed Revenue Center Code (RCC) on the UB-04 institutional bill is not payable with the submitted diagnosis for the DCMWC program.

Refer to DCMWC Procedure Manual for additional information

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Explanation of Benefits Number
Quick Reference Guide

90542
EOB NUMBER

EOB DESCRIPTION
Patient has not met the required eligibility requirements.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

FECA case status is Under Review or Under Development. Services are not payable during this case review timeframe.

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Explanation of Benefits Number

Quick Reference Guide

90671

EOB NUMBER

EOB DESCRIPTION

This care may be covered by another payer (Responsible Mine Operator).

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC program.

The billed services are covered by a responsible mine operator.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90925
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): Processed based on diagnosis-related group (DRG).

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The acute facility services submitted on the UB-04 institutional bill are not payable for the DCMWC program.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

91125
EOB NUMBER

EOB DESCRIPTION
Missing/incomplete/insufficient documentation: Nurse progress note is required with submission of home health care related services.

ADDITIONAL STEPS
Providers must resubmit the bill ensuring supporting documentation is attached. Attachments must be signed by the caregiver along with the caregiver title. Ensure the supporting documentation matches the billed claimant and date of service.

Refer to the DEEOIC policy and procedure for additional information

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Explanation of Benefits Number
Quick Reference Guide

92125
EOB NUMBER

EOB DESCRIPTION
An attachment/other documentation is required to adjudicate this claim/service: Missing documentation.

ADDITIONAL STEPS
Providers must resubmit the bill ensuring supporting documentation is attached. Attachments must be signed by the caregiver along with the caregiver title. Ensure the supporting documentation matches the billed claimant and date of service.

Refer to the DEEOIC policy and procedure for additional information

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00079
EOB NUMBER

EOB DESCRIPTION
The procedure code is inconsistent with the modifier used. Invalid combination of HCPCS modifiers.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Modifier -25 is reported for an E&M procedure code with no OPPS status indicator S, T, or X procedure code present for the same date of service. Correct and resubmit.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

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00173
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Incorrect claim form/format for inpatient service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The billed procedure code is considered an Inpatient procedure and cannot be submitted on an Outpatient bill. Correct and resubmit.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

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Explanation of Benefits Number

Quick Reference Guide

00174

EOB NUMBER

EOB DESCRIPTION

Only one visit or consultation per physician per day is covered. Only one evaluation and management code at this service level is covered during the course of care.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC programs.

When multiple E&M codes for the same date of service are submitted on an Outpatient bill, the appropriate modifiers must be appended to the procedure codes. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00176
EOB NUMBER

EOB DESCRIPTION
Exact duplicate claim/service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

When submitting multiple radiology code on Outpatient bills, the appropriate modifier must be billed. Otherwise, duplicate code may not be payable. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

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Explanation of Benefits Number

Quick Reference Guide

00183

EOB NUMBER

EOB DESCRIPTION

The procedure code is inconsistent with the modifier used: Invalid combination of modifiers.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC programs.

When a procedure is performed on both sides of the body, consider reporting the procedure with the appropriate modifier on a single line. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

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Explanation of Benefits Number

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00184

EOB NUMBER

EOB DESCRIPTION

Duplicate diagnostic or therapeutic procedures billed with a unit greater than one and or missing modifiers.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC programs.

When a billing duplicate diagnostic or therapeutic procedure codes on an Outpatient bill are processed through OPPS, the units cannot exceed the limit, and a modifier is required for some of the procedure codes. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

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00188

EOB NUMBER

EOB DESCRIPTION

Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid procedure code(s).

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC programs.

When a billing skin substitute application procedure code on an Outpatient bill are processed through OPPS, the appropriate skin substitute HCPCS code is required. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

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Explanation of Benefits Number
Quick Reference Guide

00213
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Incomplete/Invalid Procedure modifier(s).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Billing procedure codes that are considered a code pair with the same modifier suppress the NCCI editing for OPPS causing the bill lines to deny. Correct and resubmit.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

00214

EOB NUMBER

EOB DESCRIPTION

The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Procedure code incidental to primary procedure.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC programs.

When submitting incidental, other payable services must be performed and billed for the same date of service. Correct and resubmit.

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00236
EOB NUMBER

EOB DESCRIPTION
The procedure code is inconsistent with the modifier used. Invalid combination of HCPCS modifiers.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Bilateral procedure codes can only be reported once. Check the procedure code indicator to determine if the code is considered bilateral. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00253
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing Procedure Modifier(s).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

For additional information on critical care service, refer to CMS.

Medicare Claims Processing Manual (cms.gov)

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

00323

EOB NUMBER

EOB DESCRIPTION

The procedure code or diagnosis code is inconsistent with the patient's age.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC programs.

The diagnosis submitted on the Outpatient bill is incorrect for the age of the claimant listed on the bill. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00324
EOB NUMBER

EOB DESCRIPTION
The diagnosis is inconsistent with the patient's gender.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The diagnosis submitted on the Outpatient bill is incorrect for the gender of the claimant listed on the bill. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00344
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid diagnosis or condition.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

When the Outpatient bill is processed through the 3M grouper, the diagnosis codes are validated to ensure the required digits are present. If the required diagnosis digits are missing, the bill is not payable. Correct and resubmit.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00498
EOB NUMBER

EOB DESCRIPTION
Revenue code and Procedure code do not match. This should be billed with the appropriate code for these services.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Trauma response critical care service billed without the required revenue code and procedure code causes the bill line to deny.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
I/OCE Quarterly Release Files | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00740
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): Service does not qualify for payment under the Outpatient Facility Fee Schedule.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

When submitting an Outpatient bill is submitted with an inpatient only procedure, the appropriate modifier and discharge status code is required. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00741
EOB NUMBER

EOB DESCRIPTION
This service/procedure requires that a qualifying service/procedure be received and covered.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

When submitting an Outpatient bill some devices are allowed only with certain procedure codes. If any of these devices are submitted without the parent procedure code, the line denies in the 3M Grouper. Correct and resubmit.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00742
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid type of bill.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

When submitting an Observation service for a type of bill 13x or 85x, the appropriate revenue code and procedure code must be submitted on the bill. Correct and resubmit.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00743
EOB NUMBER

EOB DESCRIPTION
Multiple medical visits with the same Procedure Code and/or Revenue Code on the same day with a missing/incomplete/invalid condition code.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The 3M grouper rejects multiple medical visits on the same day with the same revenue code and missing condition code. Correct and resubmit.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00744
EOB NUMBER

EOB DESCRIPTION
Evaluation and management visit on same day as a surgical procedure.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

When an Outpatient bill is submitted with an E&M visit performed on the same day as a procedure code with a status indicator T or S, the appropriate modifier is required.

Refer to CMS for more information

Outpatient Code Editor (OCE) | CMS
Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00745
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid procedure code(s).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

For additional information on autologous blood and transfusion, refer to CMS.

Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80010
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

Established E&M procedure codes 99211 through 99215 are limited to one (1) per day for the same provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80015
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

New home visit procedure codes 99341 through 99345 are limited to one (1) visit every six months for the same provider per claimant. If visit is exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80017

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: The number of Days or Units of Service exceeds our acceptable maximum.

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC program.

The rental of a pressure support ventilator (E0464) is limited to 36 days or units per every three (3) years per claimant. If units are exceeded, the bill line denies.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80021
EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: The number of Days or Units of Service exceeds our acceptable maximum.

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC programs.

Battery for Hearing aid device (procedure code V5266) is limited to 12 units per every 366 days per claimant. If units are exceeded, the bill line denies.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80031
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The following Chest Xray procedure codes are limited to 12 units per year per claimant:

- 71250
- 71260
- 71045
- 71046
- 71048
- 76000 through 76001
- 71010 through 71034

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80032
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

Procedure codes 94640 and 94644 through 94645 are limited to six (6) units per year per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80036
EOB NUMBER

EOB DESCRIPTION
Benefit maximum for this time period or occurrence has been reached: This service is allowed 4 times in a 12-month period.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

Procedure codes 93000, 93010, and 93005 are limited to four (4) units per year per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80061
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

Before 07/15/2023

Procedure code V5011 is limited to four (4) units per year per claimant. If units are exceeded, the bill line denies.

On or After 07/15/2023

Procedure code V5011 is limited to four (4) units per 1825 days per claimant. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80062
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): This service is allowed 1 time in a 3-year period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The following procedure codes are limited to one (1) per three (3) years per claimant.

- K0800 through K0802
- K0806 through K0808
- K0812 through K0816
- K0820 through K0831
- K0835 through K0843
- K0848 through K0871
- K0877 through K0880
- K0884 through K0886
- K0898 through K0899
- K0011 through K0012
- K0014
- E1230

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80081
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Procedure code E0443 is limited to one (1) unit every 31 days. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80083
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Procedure code E0442 is limited to one (1) unit every 31 days per claimant. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80084
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Procedure code E0444 is limited to one (1) unit every 31 days per claimant. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80085

EOB NUMBER

EOB DESCRIPTION

Benefit maximum for this time period or occurrence has been reached: This service is allowed 4 times in a 12-month period.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

Procedure codes 20550 through 20551 are limited to four (4) units per year per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80088
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Procedure code A4595 is limited to two (2) units per month per claimant. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80089
EOB NUMBER

EOB DESCRIPTION
Benefit maximum for this time period or occurrence has been reached: This service is allowed 1 time in a 3-year period.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

Procedure code E1390 billed with required modifier is limited to one (1) every 1098 days per claimant. If units are exceeded, the bill line denies.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80090
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

Procedure code E1390 billed with required modifier is limited to one (1) every 1098 days per claimant. If units are exceeded, the bill line denies.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80415
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: The number of days or units of service exceeds our acceptable maximum.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

Procedure codes 90832, 90833, 90836, 90837, and 90838 are limited to two (2) units per seven (7) days per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90906
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Incorrect claim form/format for freestanding ambulatory surgery center (ASC) service. OWCP-1500 required.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

ASC Provider are required to be submitted on an OWCP 1500 and appended modifier SG to avoid bill line denying. Correct and resubmit the bill for reconsideration.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

70910
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): Not covered based on the date of injury/accident.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The billed service is not included in the Claimant's accepted condition package.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

20650

EOB NUMBER

EOB DESCRIPTION

Precertification/authorization/notification/pre-treatment absent.

ADDITIONAL STEPS

This EOB denial is specific to the DEEOIC programs.

When billing Inpatient bills and the DRG assigned is for a Transplant, authorization is required for the service. Submit an authorization request. Once authorization is approved, resubmit.

Refer to DEEOIC Authorization Tutorials for more information:

Submit New Authorization Online DEEOIC Tutorial

DEEOIC Authorization Templates (Forms Tutorial)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60915
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): This service is not a covered telehealth service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DCMWC, and DEEOIC programs.

The billed Telehealth service is not an approved Telehealth procedure. Correct and resubmit.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

40117
EOB NUMBER

EOB DESCRIPTION
The procedure code is inconsistent with the modifier used.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DCMWC, and DEEOIC programs.

The modifier billed with the procedure code is invalid or not on fille. Correct and resubmit.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule (https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

50408

EOB NUMBER

EOB DESCRIPTION

Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid Medicare Number.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DCMWC, and DEEOIC programs.

The Inpatient bill or Outpatient bill requiring a Medicare Number is missing or does not match what is listed on your provider file. Correct and resubmit.

Refer to the link below for more information on how to submit updates to your OWCP Provider file:

Updating Provider Information Resource Guide

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60217
EOB NUMBER

EOB DESCRIPTION
The procedure code is inconsistent with the provider type/specialty: This provider type/provider specialty may not bill this service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The billed service is not appropriate for an ASC facility.
Correct and resubmit.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule
(https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60961
EOB NUMBER

EOB DESCRIPTION
Revenue code and Procedure code do not match.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The billed unlisted J-code is not applicable with the billed RCC. Correct and resubmit.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80416
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: This service is allowed one time in a 6-month period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

Procedure codes 96130, 96132, 96136, 96138, and 96116 are limited to one (1) unit per 6 months per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Refer to the following DFEC Bulletin for more information:

FECA CIRCULAR NO. 22-10

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Explanation of Benefits Number

Quick Reference Guide

80417

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: The number of days or units of service exceeds our acceptable maximum.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

Procedure code 96121 is limited to three (3) units per 6 months per claimant. If units are exceeded, the bill line denies.

Refer to the following DFEC Bulletin for more information:

FECA CIRCULAR NO. 22-10

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80418

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: The number of days or units of service exceeds our acceptable maximum.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

Procedure codes 96105 and 96146 are limited to six (6) units per six (6) months per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Refer to the following DFEC Bulletin for more information:

FECA CIRCULAR NO. 22-10

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80419

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: The number of days or units of service exceeds our acceptable maximum.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

Procedure codes 96131 and 96133 are limited to seven (7) unit per six (6) months per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Refer to the following DFEC Bulletin for more information:

FECA CIRCULAR NO. 22-10

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80420

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: The number of days or units of service exceeds our acceptable maximum.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

Procedure codes 96137 and 96139 are limited to eleven (11) unit per 6 months per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Refer to the following DFEC Bulletin for more information:

FECA CIRCULAR NO. 22-10

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80058
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

Procedure codes 99347 to 99350 are limited to one (1) unit per week per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number

Quick Reference Guide

80059

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC programs.

Procedure codes 97164, 97172, and 97002 are limited to one (1) unit per month per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80060
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Procedure codes 97168 and 97004 are limited to one (1) unit per month per claimant. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90132
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid charge.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DCMWC, and DEEOIC programs.

The billed service was submitted with zero dollars or left blank. Correct and resubmit.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90918
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid/inappropriate place of service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The billed telehealth service was submitted with an invalid place of service (POS). Correct and resubmit.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90920
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): A separate claim must be submitted for each place of service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The bill was submitted with a mix of non-Telehealth place of service (POS) and Telehealth place of service (POS). Correct and resubmit.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90922
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s). This service is not a covered Telehealth service.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billed Telehealth service is not covered by the program.
Correct and resubmit.

Refer to DCMWC Procedure Manual for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90160
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid total charges.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DCMWC, and DEEOIC programs.

The total lines charges does not equal to the total billed amount. Correct and resubmit.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80003
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

Procedure code 99080 is limited to one (1) report per week for the same claimant and same Provider. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80004
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC program.

Group therapy procedure codes 90785 and 90853 are limited to one (1) per day for the same claimant and same Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80005
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Procedure code 90863 for pharmacologic management is limited to one (1) per 14 days for the same claimant and Provider. If units are exceeded, the bill line denies.

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Explanation of Benefits Number
Quick Reference Guide

81005
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: The number of days or units of service exceeds our acceptable maximum.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

Procedure code 90863 for pharmacologic management is limited to two (2) services per seven (7) days for the same claimant and Provider. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80007
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Physical Therapy Evaluation procedure codes 97161, 97162, 97163, 97169, 97170, and 97171 are limited to one (1) per every six (6) months for the same claimant and servicing Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

80008
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Occupational Therapy Evaluation procedure codes 97165, 97166, and 97167 are limited to one (1) per every six (6) months for the same claimant and servicing Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

80011
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

New Nursing facility patient visit procedure codes 99304 to 99306 are limited to one (1) per every six (6) months for the same claimant and same Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number

Quick Reference Guide

80013

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: This service is allowed one time in a 6-month period.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC and DEEOIC programs.

New Rest Home procedure codes 99324 to 99328 are limited to one (1) per every six (6) months for the same claimant and same Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

80016
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Established Patient Home visit procedure codes 99347 to 99350 are limited to one (1) per day for the same claimant and same Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

80018
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC programs.

Emergency Room procedure codes 99217 to 99220, 99281 to 99285, and 99288 are limited to twelve (12) visits per year for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80019
EOB NUMBER

EOB DESCRIPTION –
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC programs.

Before 07/15/2023

Hearing Aid procedure codes V5014 and V5267 are limited to five (5) per year for the same claimant and any Provider. If units are exceeded, the bill line denies.

On and After 07/15/2023

Hearing Aid procedure codes V5014 is limited to three (3) per 1825 days for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number

Quick Reference Guide

80020

EOB NUMBER

EOB DESCRIPTION

Benefit maximum for this time period or occurrence has been reached: Policy benefits have been exhausted.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC programs.

Hearing Aid procedure codes V5014 and V5267 are limited to $1,000.00 per year for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number

Quick Reference Guide

80421

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC programs.

Procedure codes E1800, E1801, E1802, E1805, E1806, E1810, E1811, E1812, E1815, E1816, E1818, E1820, E1821, E1825, E1830, E1831, or E1840 (Rental Extension/Flexion devices) are limited to one (1) per 31 days for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are not considered a group and must be billed with the appropriate modifier rental (RR) or purchase (NU), if applicable. If the code is submitted a without modifier, the bill line will be denied.

Refer to FECA CIRCULAR NO. 23-07 for additional information.

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Explanation of Benefits Number
Quick Reference Guide

80422
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC programs.

Procedure codes E0100, E0105, E0110, E0112, E0114, E0621 (Canes/Crutches/Slings), E0955 (Headrest), and E2378 (Actuator Replacement) are limited to one (1) per 366 days for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are not considered a group and must be billed with the appropriate modifier rental (RR) or purchase (NU), if applicable. If the code is submitted a without modifier, the bill line will be denied.

Refer to FECA CIRCULAR NO. 23-07 for additional information.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80423

EOB NUMBER

EOB DESCRIPTION

Lifetime benefit maximum has been reached: This service is paid only once in a patient's lifetime.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC programs.

Procedure codes E0670 (Segmental pneumatic appliance), E0720, E0730 (TENS devices), E0748, and E0760 (Osteogen ultrasound stimulators) are limited to one (1) per lifetime for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure codes listed above are not considered a group and must be billed with the appropriate modifier rental (RR) or purchase (NU), if applicable. If the code is submitted a without modifier, the bill line will be denied.

Refer to FECA CIRCULAR NO. 23-07 for additional information.

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Explanation of Benefits Number

Quick Reference Guide

80424

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC programs.

Procedure codes E0156, E0158, E0159 (Walker accessories), E0731 (TENS/NMES), and E2102 (Non-implanted continuous glucose monitor/receiver) are limited to one (1) per 1095 days for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure code listed above must be billed with the appropriate modifier rental (RR) or purchase (NU), if applicable. If the code is submitted without a modifier, the bill line will be denied.

Refer to FECA CIRCULAR NO. 23-07 for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80425
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC programs.

Procedure code E0120 (Residual Limb Support) is limited to twice per 1825 days for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure code listed above must be billed with the appropriate modifier rental (RR) or purchase (NU), if applicable. If the code is submitted without a modifier, the bill line will be denied.

Refer to FECA CIRCULAR NO. 23-07 for additional information.

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Explanation of Benefits Number

Quick Reference Guide

80426

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC programs.

Procedure code E0128 (Manual Swing-away) is limited to one (1) per 366 days for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure code listed above must be billed with the appropriate modifier rental (RR) or purchase (NU), if applicable. If the code is submitted without a modifier, the bill line will be denied.

Refer to FECA CIRCULAR NO. 23-07 for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

81044
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC programs.

If the procedure code billed is for a Mobility assistance devices, Wheelchair accessories, Mattresses, and Hospital beds, the equipment is limited to one (1) per 1825 days for the same claimant and any Provider. If units are exceeded, the bill line denies.

Note: The procedure code listed above must be billed with the appropriate modifier rental (RR) or purchase (NU), if applicable. If the code is submitted without a modifier, the bill line will be denied.

Refer to FECA CIRCULAR NO. 23-07 for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90971
EOB NUMBER

EOB DESCRIPTION
The procedure code is inconsistent with the modifier used. Invalid combination of HCPCS modifiers.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC programs.

If DME services are billed without the appropriate modifier, the bill service line will be denied.

Refer to FECA CIRCULAR NO. 23-07 for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80080
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Procedure code E0441 is limited to one (1) per 31 days per claimant.
If units are exceeded, the bill line denies.

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Explanation of Benefits Number
Quick Reference Guide

80904
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The following procedure codes are limited to two (2) per six (6) months per claimant.

- S9152
- 92521 through 92524

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80905
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Procedure code A4928 is limited to nine (9) per six (6) months per claimant. If units are exceeded, the bill line denies.

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Explanation of Benefits Number
Quick Reference Guide

80907
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Procedure code A4615 is limited to 500 units per six (6) months per claimant. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80908
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Procedure code A4616 is limited to 1,000 units per six (6) months per claimant. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80909
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Procedure code A4620 is limited to 40 units per six (6) months per claimant. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80910
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Procedure code E0555 is limited to 20 units per six (6) months per claimant. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80911

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS

This EOB denial is specific to the DEEOIC program.

Procedure code E1353 is limited to ten (10) units per six (6) months per claimant. If units are exceeded, the bill line denies.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80912
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The following procedure codes are limited to twelve (12) units per 366 days per claimant and modifier RR.

- E0424
- E0431
- E0433 to E0434
- E0439

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

80757
EOB NUMBER

EOB DESCRIPTION
Lifetime benefit maximum has been reached: This service is paid only once in a patient's lifetime.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The following procedure codes are limited to one (1) per life per claimant.

- 47562 through 47564
- 47600
- 47605
- 47610
- 47612
- 47620

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

81757
EOB NUMBER

EOB DESCRIPTION
Lifetime benefit maximum has been reached: Policy benefits have been exhausted.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The following procedure codes are limited to one (1) per life per claimant.

- 58150
- 58152
- 58200
- 58210
- 58240
- 58260
- 58262 through 58263
- 58267
- 58270
- 58275
- 58280
- 58285
- 58290 through 58294
- 58550
- 58552 through 58554

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number

Quick Reference Guide

82757

EOB NUMBER

EOB DESCRIPTION

Lifetime benefit maximum has been reached: Policy benefits have been exhausted.

ADDITIONAL STEPS

This EOB denial is specific to the DEEOIC program.

The following procedure codes are limited to one (1) per life per claimant.

- 58150
- 58152
- 58200
- 58210
- 58240
- 58260
- 58262 through 58263
- 58267
- 58270
- 58275
- 58280
- 58285
- 58290 through 58294
- 58550
- 58552 through 58554

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

83757
EOB NUMBER

EOB DESCRIPTION
Lifetime benefit maximum has been reached: Policy benefits have been exhausted.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Procedure codes 23900 through 23921 are limited to two (2) per life per claimant.

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

84757
EOB NUMBER

EOB DESCRIPTION
Lifetime benefit maximum has been reached: Policy benefits have been exhausted.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The following procedure codes are limited to two (2) per life per claimant.

- 19180
- 19182
- 19200
- 19240
- 19300 through 19307

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

85757
EOB NUMBER

EOB DESCRIPTION
Lifetime benefit maximum has been reached: Policy benefits have been exhausted.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The following procedure codes are limited to two (2) per life per claimant.

- 50220
- 50225
- 50230
- 50236
- 50545 through 50546

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

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Explanation of Benefits Number
Quick Reference Guide

90965
EOB NUMBER

EOB DESCRIPTION
Payment adjusted because the payer deems the information submitted does not support this many/frequency of services: The number of Days or Units of Service exceeds our acceptable maximum.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The procedure code units billed exceed the defined maximum “Per Day” allowed units. Correct and resubmit.

Refer to CMS for more information:

Medicare NCCI Medically Unlikely Edits | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90966
EOB NUMBER

EOB DESCRIPTION
Payment adjusted because the payer deems the information submitted does not support this many/frequency of services: The number of Days or Units of Service exceeds our acceptable maximum.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The procedure code units billed exceed the defined maximum “Per Day” allowed units. Correct and resubmit.

Note: The units are calculated within the same bill submitted for the same procedure and same date of service.

Refer to CMS for more information:

Medicare NCCI Medically Unlikely Edits | CMS

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Explanation of Benefits Number
Quick Reference Guide

91966
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded: The number of Days or Units of Service exceeds our acceptable maximum.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The procedure code units billed exceed the defined maximum “Per Day” allowed units. Correct and resubmit.

Note: The units is calculated based on all bills submitted for the same procedure, same date of service, and same claimant.

Refer to CMS for more information:

Medicare NCCI Medically Unlikely Edits | CMS

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Explanation of Benefits Number
Quick Reference Guide

60148
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid revenue code(s).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The line in block 42 on the UB-04 is missing a revenue code. Correct and resubmit.

Refer to Forms and Reference on the OWCP portal for additional information: OWCP Portal > Resources > Forms and References (https://owcpmed.dol.gov/portal/resources/forms-and-references)

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Explanation of Benefits Number
Quick Reference Guide

60163
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid diagnosis or condition.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The diagnosis code is missing in block 21 on the UB-04 or the diagnosis pointer is missing from line item when there are multiple diagnosis in box 21 on the OWCP 1500. Correct and resubmit.

Refer to Forms and Reference on the OWCP portal for additional information: OWCP Portal > Resources > Forms and References (https://owcpmed.dol.gov/portal/resources/forms-and-references)

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Explanation of Benefits Number
Quick Reference Guide

60195
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s).
Missing/incomplete/invalid tooth surface information.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The procedure code billed was not appended and the tooth surface is not UL, LL, UR, or LR. Correct and resubmit.

Refer to Forms and Reference on the OWCP portal for additional information: OWCP Portal > Resources > Forms and References (https://owcpmed.dol.gov/portal/resources/forms-and-references)

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Explanation of Benefits Number
Quick Reference Guide

60197
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid surgery date.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The surgical procedure is missing the corresponding surgical date. Correct and resubmit.

Refer to Forms and Reference on the OWCP portal for additional information: OWCP Portal > Resources > Forms and References (https://owcpmed.dol.gov/portal/resources/forms-and-references)

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Explanation of Benefits Number
Quick Reference Guide

60218
EOB NUMBER

EOB DESCRIPTION
The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated: Claim processed in accordance with ambulatory surgical guidelines.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

Surgical procedures that are not included in the list of surgical procedures allowable for facility fee payment to Ambulatory Surgical Center are not covered for payment to an Ambulatory Surgery Center.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule

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Explanation of Benefits Number
Quick Reference Guide

60239
EOB NUMBER

EOB DESCRIPTION
Diagnosis was invalid for the date(s) of service reported: Missing/incomplete/invalid diagnosis or condition.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

Bills with dates of service or coverage dates on or after 10/1/2015 cannot be submitted with ICD-9 diagnosis codes. Correct and resubmit.

If an injured worker's accepted condition is in ICD-9 format, convert to ICD-10 when billing.

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Explanation of Benefits Number
Quick Reference Guide

60240
EOB NUMBER

EOB DESCRIPTION
Diagnosis was invalid for the date(s) of service reported:
Missing/incomplete/invalid diagnosis or condition.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

Bills with dates of service or coverage dates before 10/1/2015 cannot be submitted with ICD-10 diagnosis codes. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

60241
EOB NUMBER

EOB DESCRIPTION
Diagnosis was invalid for the date(s) of service reported: Missing/incomplete/invalid diagnosis or condition.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

Both an ICD-9 and ICD-10 diagnosis code cannot be submitted on the same bill. ICD-9 codes can only be billed for dates of service prior to 10/1/2015, and ICD-10 codes can only be billed for dates of service on or after 10/1/12015. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

60243
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid surgical procedure code(s).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

An ICD-9 Surgical procedure code was billed for a date of service on or after 10/1/2015 dates of service. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

60244
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid surgical procedure code(s).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

An ICD-10 surgical procedure code was billed for a date of service prior to 10/1/2015 dates of service. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

60245
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid surgical procedure code(s).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

Both ICD-9 and ICD-10 procedure codes cannot be submitted on the same bill. ICD-9 codes can only be billed for dates of service prior to 10/1/2015, and ICD-10 codes can only be billed for dates of service on or after 10/1/2015. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

60258
EOB NUMBER

EOB DESCRIPTION
This service/procedure requires that a qualifying service/procedure be received and covered: The qualifying other service/procedure has not been received/adjudicated: Missing/incomplete/invalid procedure code(s).

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The procedure code was not billed in conjunction with the basic ambulance code. Correct and resubmit.

Refer to DCMWC Procedure Manual for additional information

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Explanation of Benefits Number
Quick Reference Guide

60280
EOB NUMBER

EOB DESCRIPTION
The procedure/revenue code is inconsistent with the type of bill.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

An inpatient bill was submitted but the accommodation revenue code was missing from the first line item. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

60324
EOB NUMBER

EOB DESCRIPTION
The diagnosis is inconsistent with the patient's gender.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The billed diagnosis code is incompatible for the sex of the claimant. Log in to the WCMBP portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the claimant. If the diagnosis code is covered for the claimant sex, resubmit the bill for reconsideration.

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Explanation of Benefits Number

Quick Reference Guide

60347

EOB NUMBER

EOB DESCRIPTION

Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid revenue code(s).

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The revenue code submitted on the UB-04 is invalid. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

60451
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s). Not covered when performed for the reported diagnosis.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The billed secondary diagnosis code is not covered by the program. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the program and claimant. If the diagnosis code is covered for the program and claimant, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

60454
EOB NUMBER

EOB DESCRIPTION
The diagnosis is inconsistent with the patient's age.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The secondary diagnosis conflicts with the age of the claimant. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the claimant. If the diagnosis code is covered for the claimant age, resubmit the bill for reconsideration.

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Explanation of Benefits Number

Quick Reference Guide

60455

EOB NUMBER

EOB DESCRIPTION

The diagnosis is inconsistent with the patient's gender.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The secondary diagnosis conflicts with the sex of the claimant. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the program and claimant sex. If the diagnosis code is covered for the program and claimant sex, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

60456
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid/unspecified diagnosis.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed secondary diagnosis code is not specific. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the program and claimant. If the diagnosis code is covered for the program and claimant, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

60550
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid surgical procedure code.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed surgical procedure code is not on file or invalid.

Refer to ICD-10 Resources | CMS for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

81021
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

Procedure code V5266 is limited to 30 units per six (6) months per claimant. If units are exceeded, the bill line denies.

Refer to FECA CIRCULAR NO. 23-08 for additional information.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80151

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

The following procedure codes are limited to one (1) per 730 days per claimant.

- V5264
- V5265
- V5275

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Refer to FECA CIRCULAR NO. 23-08 for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80152
EOB NUMBER

EOB DESCRIPTION
Coverage/program guidelines were exceeded

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

The following procedure codes are limited to one (1) per 1825 days per claimant.

V5010, V5020, V5030, V5040, V5050, V5060, V5070, V5080, V5090, V5100, V5110, V5120, V5130, V5140, V5150, V5160, V5170, V5171, V5172, V5180, V5181, V5190, V5200, V5210, V5211, V5212, V5213, V5214, V5215, V5220, V5221, V5230, V5240, V5241, V5242, V5243, V5244, V5245, V5246, V5247, V5248, V5249, V5250, V5251, V5252, V5253, V5254, V5255, V5256, V5257, V5258, V5259, V5260, V5261, V5262, V5263, V5267, V5268, V5269, V5270, V5271, V5272, V5273, V5281, V5282, V5283, V5284, V5285, V5286, V5287, V5288, V5289, V5290, V5298

If units are exceeded, the bill line denies.

Note: The procedure codes listed above are considered a group; therefore, the limitation is applied to the group not the individual procedure code.

Refer to FECA CIRCULAR NO. 23-08 for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80079
EOB NUMBER

EOB DESCRIPTION
Mutually exclusive procedures cannot be done in the same day/setting.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

This procedure code is considered a mutually exclusive or incidental service submitted for the same claimant and same date of service. Correct and resubmit.

Refer to Correct Coding Initiative (CCI) guidance for further information.

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Explanation of Benefits Number
Quick Reference Guide

70861
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): This procedure code is not covered. The date(s) of service was not within the effective dates of the claimant's accepted conditions.

ADDITIONAL STEPS
The billed diagnosis date of service does not fail within the date span of a covered claimant’s accepted conditions. Correct and resubmit.

Refer to Provider Tips for more information:

Services for Accepted Conditions.pdf (dol.gov)

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Explanation of Benefits Number

Quick Reference Guide

40439

EOB NUMBER

EOB DESCRIPTION

The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Separately billed services/tests have been bundled as they are considered components of the same procedure.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

This procedure code billed is considered a bundled service, which is not separately payable.

Refer to the OWCP Medical Fee Schedule for more information:

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

81019
EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

The following procedure codes are limited to three (3) per 1825 days per claimant.

- V5014

Refer to FECA CIRCULAR NO. 23-08 for additional information.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

81061

EOB NUMBER

EOB DESCRIPTION

Coverage/program guidelines were exceeded: Exceeds number/frequency approved/allowed within time period.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

The following procedure codes are limited to four (4) per 1825 days per claimant.

- V5011

Refer to FECA CIRCULAR NO. 23-08 for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00247
EOB NUMBER

EOB DESCRIPTION
This service/procedure requires that a qualifying service/procedure be received and covered. Missing/incomplete/invalid procedure code(s).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The service or procedure requires that a qualifying service or procedure be received and covered.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00642
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s).
Missing/incomplete/invalid principal diagnosis.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The primary diagnosis code submitted on the bill is not valid.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00803
EOB NUMBER

EOB DESCRIPTION
The procedure code is inconsistent with the modifier used. Invalid combination of HCPCS modifiers.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

Bilateral procedure codes can only be reported once. Check the procedure code indicator to determine if the code is considered bilateral. Correct and resubmit.

Refer to CMS for more information:

Outpatient Code Editor (OCE) | CMS
Hospital Outpatient Regulations and Notices | CMS

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00823
EOB NUMBER

EOB DESCRIPTION
The Diagnostic Related Group is inconsistent with the patient's gender.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The grouper assigned a DRG, which conflicts with the gender of the claimant submitted on the bill.

Refer to CMS for more information:

Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00824
EOB NUMBER

EOB DESCRIPTION
The Diagnostic Related Group is inconsistent with the patient's age.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The grouper assigned a DRG which conflicts with the age of the claimant submitted on the bill.

Refer to CMS for more information:

Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00831
EOB NUMBER

EOB DESCRIPTION
The procedure/revenue code is inconsistent with the patient's age.

ADDITIONAL STEPS

The billed procedure code, diagnosis code, or revenue center code conflicts with the age of the claimant submitted on the bill.

The grouper assigned a DRG, which conflicts with the age of the claimant submitted on the bill.

Refer to CMS for more information:

Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

00832
EOB NUMBER

EOB DESCRIPTION
The diagnosis is inconsistent with the patient's gender.

ADDITIONAL STEPS

The billed procedure code, diagnosis code, or revenue center code conflicts with the gender of the claimant submitted on the bill.

The grouper assigned a DRG, which conflicts with the gender of the claimant submitted on the bill.

Refer to CMS for more information:

Medicare Claims Processing Manual

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Explanation of Benefits Number
Quick Reference Guide

00835
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid principal diagnosis.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The primary diagnosis code submitted on the bill is not valid.

Refer to CMS for more information:

Medicare Claims Processing Manual

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90569
EOB NUMBER

EOB DESCRIPTION
The amount paid by the third party payer results in a balance of zero.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

Total allowable charges less amount paid by Third party results in balance of zero.

Refer to the DEEOIC policy and procedure for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90595
EOB NUMBER

EOB DESCRIPTION
Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The bill date of service is prior to start of energy program. Correct and resubmit.

Refer to the DEEOIC policy and procedure for additional information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90916
EOB NUMBER

EOB DESCRIPTION
Payment is denied when performed/billed by this type of provider in this type of facility. Not covered when performed in this place of service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The Telehealth services can only be performed when the claimant is located on one of the approved originating sites.

Refer the below hyperlink for additional information:

DFEC Telehealth

DEEOIC Telehealth

DCMWC Telehealth

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90917
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): The modifier GQ is not appropriate for the service location.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The modifier is applicable only with services provided for federal telemedicine demonstration programs in Alaska and Hawaii.

Refer to the DEEOIC Procedure Manual for addition information

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90930
EOB NUMBER

EOB DESCRIPTION
Attachment/other documentation referenced on the claim was not received. Missing documentation.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC and DCMWC programs.

The Telehealth services for distant site require attachment providing details of the originating site. Submit the medical documentation.

Refer the hyperlink below for additional information

DEEOIC Telehealth

DCMWC Telehealth

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

91015
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid replacement claim information.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The replacement claim information is missing or invalid. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

91016
EOB NUMBER

EOB DESCRIPTION
Claim/service has submission/billing error(s): invalid billing provider/supplier primary identifier.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The EDI transaction is missing the billing provider number. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

91017
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid patient identifier.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The EDI transaction was submitted with an invalid or missing the case number. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

91018
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid replacement claim type.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The replacement claim type information is missing or invalid. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

91020
EOB NUMBER

EOB DESCRIPTION
ICD-9 Diagnosis was invalid for the date(s) of service reported.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The ICD-9 Diagnosis was invalid for the dates of service submitted on bill. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

91022
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid ICD Indicator.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The Diagnosis indicator is missing or invalid for the dates of service submitted on bill. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

91023
EOB NUMBER

EOB DESCRIPTION
ICD10 POTENTIAL SPLIT BILL.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The Diagnosis is missing or invalid for the dates of service submitted on bill. Correct and resubmit.

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Explanation of Benefits Number
Quick Reference Guide

50295
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider taxonomy.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The bill was submitted without the required billing provider taxonomy number or an invalid taxonomy based on your provider type. When billing for services provided to injured or ill workers for the Office of Workers' Compensation Programs, a taxonomy number must be included on the submitted bill. Resubmit the bill with the correct billing provider taxonomy.

Note: If the taxonomy listed on your bill is not found on your provider file, you will need to update your provider file to include the correct taxonomy for the service you are providing. Select the hyperlink with instructions on how to add the taxonomy to your provider file.

Updating Provider Information in the Provider Portal.

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Explanation of Benefits Number
Quick Reference Guide

50297
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider NPI and/or taxonomy.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The bill was submitted without the required servicing provider NPI and/or valid taxonomy on the bill header. When billing for services provided to injured or ill workers for the Office of Workers' Compensation Programs, the servicing provider NPI and taxonomy number must be included on the submitted bill. Resubmit the bill with the correct servicing provider NPI and taxonomy.

Note: If the servicing provider NPI and/or taxonomy listed on your bill are not found on your provider file, you will need to update your provider file to include the servicing provider NPI and taxonomy for the medical service being provided to the claimant. Select the hyperlink with instructions on how to add the taxonomy to your provider file.

Updating Provider Information in the Provider Portal.

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Explanation of Benefits Number
Quick Reference Guide

51297
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid rendering provider NPI and/or taxonomy.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The bill was submitted without the required servicing provider NPI and/or valid taxonomy on the bill service line. When billing for services provided to injured or ill workers for the Office of Workers' Compensation Programs, the servicing provider NPI and taxonomy number must be included on the submitted bill. Resubmit the bill with the correct servicing provider NPI and taxonomy.

Note: If the servicing provider NPI and/or taxonomy listed on your bill are not found on your provider file, you will need to update your provider file to include the servicing provider NPI and taxonomy for the medical service being provided to the claimant. Select the hyperlink with instructions on how to add the taxonomy to your provider file.

Updating Provider Information in the Provider Portal.

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Explanation of Benefits Number
Quick Reference Guide

50303
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). The billed procedure code is not payable for the submitted taxonomy and/or the Submitted taxonomy is not on OWCP Provider file.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed procedure code is not payable for the submitted taxonomy or the submitted taxonomy is not on the OWCP Provider file. Correct and resubmit the bill.

Note: If the bill procedure code is associated with the taxonomy found on your provider file, you will need to update your provider file to include the correct taxonomy for the service you are providing. Select the hyperlink with instructions on how to add the taxonomy to your provider file.

Updating Provider Information in the Provider Portal.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

51303
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). The billed revenue code is not payable for the submitted taxonomy and/or the Submitted taxonomy is not on OWCP Provider file

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

If the bill Revenue code is associated with the taxonomy found on your provider file, you will need to update your provider file to include the correct taxonomy for the service you are providing. Select the hyperlink with instructions on how to add the taxonomy to your provider file.

Updating Provider Information in the Provider Portal.

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Explanation of Benefits Number

Quick Reference Guide

50294

EOB NUMBER

EOB DESCRIPTION

National Provider Identifier - Not matched: Missing/incomplete/invalid billing provider/supplier primary identifier.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The bill was submitted without the required billing provider NPI number or NPI billed does not match the NPI on the provider file. When billing for services provided to injured or ill workers for the Office of Workers' Compensation Programs, a NPI number must be included on the submitted bill and match the NPI on your provider file. Resubmit the bill with the correct billing provider NPI.

Note: If the NPI listed on your bill is not found on your provider file, you will need to update your provider file to include the correct taxonomy for the service you are providing. Select the hyperlink with instructions on how to add the taxonomy to your provider file.

Updating Provider Information in the Provider Portal.

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Explanation of Benefits Number

Quick Reference Guide

20733

EOB NUMBER

EOB DESCRIPTION

Precertification/notification/authorization/pre-treatment exceeded: The number of Days or Units of Service exceeds our acceptable maximum.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The edit post when there is authorization on file for the claimant, provider, DOS, and procedure code submitted on the bill, but the billed units exceed the authorized units. Submit a correction authorization to increase the authorization units. Once the units have been increased, resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

21733
EOB NUMBER

EOB DESCRIPTION
Precertification/notification/authorization/pre-treatment exceeded.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The edit post when there is authorization on file for the claimant, provider, DOS, and procedure code submitted on the bill, but the billed amount exceed the authorized amount. Submit a correction authorization to increase the authorization amount. Once the units have been increased, resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

30250

EOB NUMBER

EOB DESCRIPTION

Patient cannot be identified as our insured.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The claimant ID submitted on the bill is not on file. Log in to the WCMBP Portal to check the claimant eligibility to ensure the correct case number was submitted on the bill. If the wrong case number was submitted on the bill, correct and resubmit.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

30271
EOB NUMBER

EOB DESCRIPTION
Patient has not met the required eligibility requirements for the dates of service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The claimant ID submitted on the bill is not eligible for the DOS. Log in to the WCMBP Portal to check the claimant eligibility to ensure the claimant is eligible for the date of service that was submitted on the bill. If the claimant is eligible for the date of service. Resubmit for correction.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

30401
EOB NUMBER

EOB DESCRIPTION
Expenses incurred after coverage terminated.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

The billed service was submitted 180 days after closure of the claimant's case. Log in to the WCMBP Portal to check the claimant eligibility to ensure the claimant is eligible for the date of service that was submitted on the bill. If the claimant is eligible for the date of service. Resubmit for correction.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

30538
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid patient birth date.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed date of birth does not match the date of birth on the claimant eligibility file. Check for keying error. If an error was submitted on your bill, correct and resubmit the bill for reconsideration. If the date of birth was submitted correctly, contact the claimant and confirm the date of birth.

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Explanation of Benefits Number
Quick Reference Guide

30589
EOB NUMBER

EOB DESCRIPTION
The date of birth follows the date of service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed date of service is before the claimant's date of birth. Check for keying error. If an error was submitted on your bill, correct and resubmit the bill for reconsideration. If the date of birth was submitted correctly, contact the claimant and confirm the date of birth.

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Explanation of Benefits Number
Quick Reference Guide

30597
EOB NUMBER

EOB DESCRIPTION
Expenses incurred after coverage terminated.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

The claimant's case is closed for the date of service. Log in to the WCMBP Portal to check the claimant eligibility to ensure the claimant is eligible for the date of service that was submitted on the bill. If the claimant is eligible for the date of service. Resubmit for correction.

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Explanation of Benefits Number
Quick Reference Guide

30652
EOB NUMBER

EOB DESCRIPTION
Precertification/authorization/notification/pre-treatment absent.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

The billed procedure is only payable within 15 days from claimant's date of injury. Submit an authorization for the claimant, date of service, procedure code unit and/or dollar amount depending on the authorization type. Once the authorization is approved, resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

31652
EOB NUMBER

EOB DESCRIPTION
Precertification/authorization/notification/pre-treatment absent.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

The billed procedure is only payable within 15 days from claimant's date of injury. Submit an authorization for the claimant, date of service, procedure code unit and/or dollar amount depending on the authorization type. Once the authorization is approved, resubmit the bill for reconsideration.

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Explanation of Benefits Number

Quick Reference Guide

30655

EOB NUMBER

EOB DESCRIPTION

Precertification/authorization/notification/pre-treatment absent.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

The billed procedure is not payable during the claimant's CA-16 period. Submit an authorization for the claimant, date of service, procedure code unit and/or dollar amount depending on the authorization type. Once the authorization is approved, resubmit the bill for reconsideration.

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Explanation of Benefits Number

Quick Reference Guide

31655

EOB NUMBER

EOB DESCRIPTION

Precertification/authorization/notification/pre-treatment absent.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

The billed procedure is not payable during the claimant's CA-15 period. Submit an authorization for the claimant, date of service, procedure code unit and/or dollar amount depending on the authorization type. Once the authorization is approved, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

40109
EOB NUMBER

EOB DESCRIPTION
The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. These services are not covered when performed within the global period of another service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The E&M service is billed within a global surgery period, therefore payment is included in the payment for the surgery.

Refer to: Medicare Claims Processing Manual (cms.gov)

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Explanation of Benefits Number
Quick Reference Guide

40111
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): Service not payable with other service rendered on the same date.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

An E&M service and surgical procedure is billed for the same DOS and same claimant.

Refer to: Medicare Claims Processing Manual (cms.gov) for additional information.

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Explanation of Benefits Number
Quick Reference Guide

40114
EOB NUMBER

EOB DESCRIPTION
Allowed amount has been reduced because a component of the basic procedure/test was paid. Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The surgery procedure is cutting back due to an E&M service that previously paid for the same claimant within the global period.

Refer to: Medicare Claims Processing Manual (cms.gov) for additional information.

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Explanation of Benefits Number
Quick Reference Guide

41114
EOB NUMBER

EOB DESCRIPTION
Allowed amount has been reduced because a component of the basic procedure/test was paid. Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The surgery procedure is cutting back due to an E&M service that previously paid for the same claimant within the global period.

Refer to: Medicare Claims Processing Manual (cms.gov) for additional information.

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Explanation of Benefits Number
Quick Reference Guide

40140
EOB NUMBER

EOB DESCRIPTION
Processed based on multiple or concurrent procedure rules.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

When multiple anesthesia procedures are performed during a single anesthetic administration, reimbursement is based on the line representing the most complex procedure.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

40207
EOB NUMBER

EOB DESCRIPTION
Processed based on multiple or concurrent procedure rules.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The bill was submitted with multiple surgery procedure and multiple surgery reduction is applied.

Refer to: Medicare Claims Processing Manual (cms.gov) for additional information.

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Explanation of Benefits Number

Quick Reference Guide

40305

EOB NUMBER

EOB DESCRIPTION

Claim/service lacks information or has submission/billing error(s). Invalid combination of modifiers.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The bill was submitted with an Anesthesia procedure code, but the appropriate modifier is missing. Correct and resubmit the bill for reconsideration.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule

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Explanation of Benefits Number

Quick Reference Guide

40905

EOB NUMBER

EOB DESCRIPTION

Claim/service lacks information or has submission/billing error(s). Incomplete/Invalid Procedure modifier(s).

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The ASC provider submitted the procedure code without the appropriate “SG” modifier. Correct and resubmit the bill for reconsideration.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50261
EOB NUMBER

EOB DESCRIPTION
The provider must update license information with the payer.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The license on the provider file will expire within 30 or 60 days. To avoid delays in payment, select the hyperlink with instructions on how to update the license in your provider file.

Updating Provider Information in the Provider Portal.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50300
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider identifier.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billing provider ID listed on the bill is not on file. Review the bill to ensure the correct provider number was submitted. If the provider was incorrectly submitted, correct and resubmit for reconsideration.

Refer to WCMBP Portal for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50306
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid billing provider identifier.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billing provider ID listed on the bill is a servicing provider. Only billing provider IDs are allowed to submit for reimbursement. Submit the bill with the billing provider ID in the appropriate field and the serving provider NPI and taxonomy in the appropriate field for reconsideration.

Refer to WCMBP Portal for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50320
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The payment on file is not set up as EFT. To avoid delays in payment, select the hyperlink with instructions on how to update the EFT information in your provider file.

Updating Provider Information in the Provider Portal.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50328
EOB NUMBER

EOB DESCRIPTION
National Provider Identifier - Not matched: Missing/incomplete/invalid rendering provider primary identifier.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The servicing provider NPI is not associated with group provider.

Note: If the NPI listed on your bill is not found in your provider file, you will need to update your provider file to include the correct taxonomy for the service you are providing. Select the hyperlink with instructions on how to add the taxonomy to your provider file.

Updating Provider Information in the Provider Portal.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50405
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): This provider is excluded.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The provider ID listed on the bill is excluded from payment.

Refer to WCMBP Portal for additional information.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

50447

EOB NUMBER

EOB DESCRIPTION

Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid service facility primary address.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billing provider zip code is missing or invalid. Correct and resubmit.

Refer to WCMBP Portal for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

51447
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid service facility primary address.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The zip code is missing for Home Health service. Correct and resubmit.

Refer to WCMBP Portal for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50524
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): Patient not enrolled in the same program as the billing provider on the date of service.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billing provider ID is not affiliated with the program that the claimant is enrolled in. Correct and resubmit.

Refer to WCMBP Portal for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50610
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid taxpayer identification number (TIN).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The tax ID submitted on the bill is missing or invalid. Correct and resubmit.

Refer to WCMBP Portal for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50612
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s). Missing/incomplete/invalid taxpayer identification number (TIN).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The Tax ID submitted on the bill does not match the Tax ID on the provider file. Correct and resubmit.

Refer to WCMBP Portal for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

50901
EOB NUMBER

EOB DESCRIPTION
Payment is denied when performed/billed by this type of provider: This provider type/provider specialty may not bill this service

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billing provider ID is not payable for the program. To confirm you are enrolled in the correct program, log in to your provider profile.

Refer to WCMBP Portal for additional information.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

70911
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): Not covered based on the date of injury/accident.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

The procedure code billed is not covered.

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule
(https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80071
EOB NUMBER

EOB DESCRIPTION
This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated: Add-on code cannot be billed by itself.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC program.

The billed procedure code is used as an add-on to another procedure code and the base code was not billed for the same date of service.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80072
EOB NUMBER

EOB DESCRIPTION
Mutually exclusive procedures cannot be done in the same day/setting.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed procedure code is mutually exclusive with another billed procedure code for the same date of service and same claimant.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80073
EOB NUMBER

EOB DESCRIPTION
Mutually exclusive procedures cannot be done in the same day/setting.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed procedure code is mutually exclusive with another procedure code billed with overlapping date of service.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80075

EOB NUMBER

EOB DESCRIPTION

The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated: Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed procedure code is a component of an already billed procedure code with overlapping dates of service.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

80077

EOB NUMBER

EOB DESCRIPTION

The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated: Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed procedure code is a comprehensive code for which the component procedure code has already been paid for the same date of service.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

80078
EOB NUMBER

EOB DESCRIPTION
Allowed amount has been reduced because a component of the basic procedure/test was paid.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, DCMWC programs.

The billed procedure code is a component that has been previously paid and service billed is for the comprehensive procedure which has been reduce by the amount paid for the component procedure.

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Explanation of Benefits Number

Quick Reference Guide

20487

EOB NUMBER

EOB DESCRIPTION

Precertification/authorization/notification/pre-treatment absent.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC program.

The billed procedure and amount has exceeded the short form closure authoration. Submit an authorization for the claimant, date of service, procedure code unit and/or dollar amount depending on the authorization type. Once the authorization is approved, resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90112
EOB NUMBER

EOB DESCRIPTION
Claim/service spans multiple months. Rebill services on separate claim lines.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billed service cannot be billed with a date range of two or more months. Please correct and resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

20919
EOB NUMBER

EOB DESCRIPTION
Precertification/authorization/notification/pre-treatment absent.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC and DEEOIC programs.

The billed Telehealth service requires authorization. Submit an authorization for the claimant, date of service, procedure code unit and/or dollar amount depending on the authorization type. Once the authorization is approved, resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

30219
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): Service date outside of the approved treatment plan service dates.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

The billed service was submitted 180 days after closure of the claimant's case. Log in to the WCMBP Portal to check the claimant eligibility to ensure the claimant is eligible for the date of service that was submitted on the bill. If the claimant is eligible for the date of service. Resubmit for correction.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

30265
EOB NUMBER

EOB DESCRIPTION
This care may be covered by another payer per coordination of benefits.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC program.

The care may be covered by another payer, therefore no payment can be made at this time. Have the claimant contact their CE.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

30557

EOB NUMBER

EOB DESCRIPTION

This care may be covered by another payer per coordination of benefits. If applicable, resubmit the claim/service with documentation from the State Workers' Compensation.

ADDITIONAL STEPS

This EOB denial is specific to the DEEOIC program.

The claimant has a total or partial medical offset that has not been satisfied. Have the claimant contact their case worker.

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Explanation of Benefits Number

Quick Reference Guide

31557

EOB NUMBER

EOB DESCRIPTION

This care may be covered by another payer per coordination of benefits. If applicable, resubmit the claim/service with documentation from the State Workers' Compensation.

ADDITIONAL STEPS

This EOB denial is specific to the DCMWC program.

The claimant has a total or partial medical offset that has not been satisfied. Have the claimant contact their case worker.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

30403
EOB NUMBER

EOB DESCRIPTION

Billing date predates service date: Not covered based on the date of injury/accident.

ADDITIONAL STEPS

The bill date on the claim is prior to the claimant date of injury. Log in to the WCMBP Portal to check the claimant's eligibility to ensure the claimant is eligible for the date of service. If the claimant is eligible for the date of service, resubmit the bill for reconsideration which can be done through DDE, EDI or Paper.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

30534
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid patient birth date.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The billed date of birth does not match the date of birth on the claimant eligibility file. Check for keying error. If an error was submitted on your bill, correct and resubmit the bill for reconsideration. If the date of birth was submitted correctly, contact the claimant and confirm the date of birth.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

60432

EOB NUMBER

EOB DESCRIPTION

Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service: This should be billed with the appropriate code for these services.

ADDITIONAL STEPS

The unlisted codes must be reviewed to determine if a better code is applicable or the NDC # is required when billing unspecified J-code such as J8499 J3490 J8999 and J9999

Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule (https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

60434

EOB NUMBER

EOB DESCRIPTION

The procedure/revenue code is inconsistent with the patient's age: Not eligible due to the patient's age.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The procedure code conflicts with the age of the claimant.
Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the claimant. If the diagnosis code is covered for the claimant age, resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number

Quick Reference Guide

60435

EOB NUMBER

EOB DESCRIPTION

The procedure/revenue code is inconsistent with the patient's age: Not eligible due to the patient's age.

ADDITIONAL STEPS

This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The procedure code conflicts with the sex of the claimant.
Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the claimant. If the diagnosis code is covered for the claimant age, resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60551
EOB NUMBER

EOB DESCRIPTION
Non-covered surgical procedure code.

ADDITIONAL STEPS
The billed surgical code is not a covered service. Log in to the WCMBP Portal to check the claimant's eligibility to ensure the procedure code is covered for the date of service and claimant. If the procedure code is covered for the date of service and claimant, resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60654
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): Sales tax is not covered for the services billed, the date of service billed, and/or not allowed in the servicing state.

ADDITIONAL STEPS
The bill procedure code is considered sales tax which is only payable for Hawaii. If the state is not Hawaii, the sales tax is not payable.

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Explanation of Benefits Number
Quick Reference Guide

60821
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid billing provider/supplier address.

ADDITIONAL STEPS
The zip code submitted on the bill is not a valid zip code nor is it listed in the zip code database (GPCI).
Refer to the OWCP Medical Fee Schedule for more information:

OWCP Medical Fee Schedule (https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60170
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid/inappropriate place of service.

ADDITIONAL STEPS
The place of service submitted on the bill is not valid or missing. Refer to the CMS website for more information:

CMS Website

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Explanation of Benefits Number
Quick Reference Guide

60323
EOB NUMBER

EOB DESCRIPTION
The diagnosis is inconsistent with the patient's age.

ADDITIONAL STEPS
The billed diagnosis code is incompatible for the age of the claimant. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the claimant. If the diagnosis code is covered for the claimant, resubmit the bill for reconsideration.

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Explanation of Benefits Number

Quick Reference Guide

60346

EOB NUMBER

EOB DESCRIPTION

Claim/service lacks information or has submission/billing error(s): You are required to code to the highest level of specificity.

ADDITIONAL STEPS

The primary/principal diagnosis code submitted is not a specific diagnosis code. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the claimant. If the diagnosis code is covered for the claimant, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

60437
EOB NUMBER

EOB DESCRIPTION
Procedure code was invalid on the date of service: Procedure code billed is not correct/valid for the services billed or the date of service billed.

ADDITIONAL STEPS
The procedure code submitted on the bill is not a covered for the date of service. Correct and resubmit for reconsideration.

Refer to the OWCP Medical Fee Schedule for more information:
OWCP Medical Fee Schedule
(https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60499
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid diagnosis or condition.

ADDITIONAL STEPS
The diagnosis pointer is missing on the bill line. Check the bill to ensure a diagnosis code pointer is included on the service line. If the diagnosis code is present on the bill, resubmit for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

60522
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.

ADDITIONAL STEPS
The procedure code submitted does not have fee schedule rate for the date of service.

Refer to the OWCP Medical Fee Schedule for more information:
OWCP Medical Fee Schedule
(https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60548
EOB NUMBER

EOB DESCRIPTION
This procedure is not paid separately: This service/report cannot be billed separately.

ADDITIONAL STEPS
Procedure codes A4365, A4450, A4452, A4455, A4456, A4556, A4558, A4630, A5120, A5126, or A6250 are not separately payable. Correct and resubmit with a payable procedure code.

Refer to the OWCP Medical Fee Schedule for more information:
OWCP Medical Fee Schedule
(https://www.dol.gov/agencies/owcp/regs/feeschedule/fee)

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60554
EOB NUMBER

EOB DESCRIPTION
The surgical procedure code is inconsistent with the patient's age: Not eligible due to the patient's age.

ADDITIONAL STEPS
The surgical procedure code conflicts with the age of the claimant. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the claimant. If the diagnosis code is covered for the claimant age, resubmit the bill for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

60555
EOB NUMBER

EOB DESCRIPTION
The procedure/revenue code is inconsistent with the patient's gender.

ADDITIONAL STEPS
The surgical procedure code conflicts with the sex of the claimant. Log in to the WCMBP Portal to o check the claimant's eligibility using the billed diagnosis code to ensure it is covered for the claimant. If the diagnosis code is covered for the claimant sex, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

70209
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid diagnosis or condition for Prompt Pay type of bill.

ADDITIONAL STEPS
The prompt pay bill was submitted with diagnosis code that is not applicable to the prompt pay submission.

Refer to DEEOIC Procedure Manual for addition information.

Refer to DCMWC Procedure Manual for additional information.

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Explanation of Benefits Number
Quick Reference Guide

70298
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid treatment authorization code and diagnosis on the claim/service is not related to the claimant's accepted condition.

ADDITIONAL STEPS
The bill was submitted with a diagnosis code not accepted for the claimant's injury, authorization is not on file for the surgery procedure code for the date of service submitted on the bill, or both.

Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code and procedure code to ensure they are covered for the date of service and the claimant. If the diagnosis code and procedure code are covered for the claimant, resubmit the bill for reconsideration. Also, if the service requires authorization, make sure authorization is on file for the surgical procedure code.

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Explanation of Benefits Number
Quick Reference Guide

70307
EOB NUMBER

EOB DESCRIPTION
Non-covered charge(s): Services not related to the specific incident/claim/accident/loss/accepted condition being reported.

ADDITIONAL STEPS
The billed procedure and NDC is not related to the accepted conditions on file for the claimant. Log in to the WCMBP Portal to check the claimant's eligibility using the billed diagnosis code and NDC to ensure they are covered for the date of service and the claimant. If the diagnosis code and NDC are covered for the claimant, resubmit the bill for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

90503
EOB NUMBER

EOB DESCRIPTION
An attachment/other documentation is required to adjudicate this claim/service. Missing documentation.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billed procedure code is was not submitted with the appropriate modifier and documentation to support the consultation. Please correct and submit the appropriate documentation for the service.

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Explanation of Benefits Number
Quick Reference Guide

90504
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid/ deactivated/withdrawn injection name.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billed injection name or NDC was not submitted on the bill. Please correct and resubmit for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90505
EOB NUMBER

EOB DESCRIPTION
An attachment/other documentation is required to adjudicate this claim/service: Missing Physician Statement with patient's information/documentation.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billed DME service is missing the supporting documentation for the purchase or rental. Please resubmit the bill with the appropriation documentation for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

90506
EOB NUMBER

EOB DESCRIPTION
Attachment/other documentation referenced on the claim was not received. Missing pathology report.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billed pathology service is missing the supporting documentation. Please resubmit the bill with the appropriate documentation for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

90507
EOB NUMBER

EOB DESCRIPTION
An attachment/other documentation is required to adjudicate this claim/service: Missing valid modifier indicating destination points.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billed ambulance service is missing the supporting documentation. Please resubmit the bill with the appropriate documentation for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90508
EOB NUMBER

EOB DESCRIPTION
An attachment/other documentation is required to adjudicate this claim/service. Missing documentation.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The billed home visit is missing the supporting documentation signed by the physician. Please resubmit the bill with the appropriate documentation for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90584
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Rebill services on separate claims.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The provider must submit two separate bills for medically directed anesthesia procedures: one for the anesthesiologist and one for the anesthetist. Correct and resubmit for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90681
EOB NUMBER

EOB DESCRIPTION
Billing date predates service date: Missing/incomplete/invalid "from" date(s) of service.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC and DCMWC programs.

The first date of service billed is after the bill received date. Correct and resubmit for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90902
EOB NUMBER

EOB DESCRIPTION
The attachment/other documentation that was received was incomplete or deficient: Incomplete/invalid documentation.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

Anesthesia bills with modifier “AD” must be submitted with supporting documentation. Resubmit with documentation supporting the usage of modifier “AD.”

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Explanation of Benefits Number
Quick Reference Guide

90942
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The NDC submitted on the bill is not payable for the program. Correct and resubmit for reconsideration.

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Explanation of Benefits Number
Quick Reference Guide

90227
EOB NUMBER

EOB DESCRIPTION
This care may be covered by another payer per coordination of benefits.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The date of service submitted on the bill is prior to the medical offset date on the claimant file. Correct and resubmit for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90255
EOB NUMBER

EOB DESCRIPTION
An attachment/other documentation is required to adjudicate this claim/service. Missing documentation: Rehabilitative Therapy Services must be accompanied by treatment notes.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The Rehabilitative bill was submitted without an appropriate attachment. Resubmit with documentation supporting the rehabilitative service.

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Explanation of Benefits Number
Quick Reference Guide

90378
EOB NUMBER

EOB DESCRIPTION
Third party payment exceeds the total reimbursement amount.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The bill was submitted with third-party amount, which was previously paid. The reimbursement is less than amount already paid.

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Explanation of Benefits Number
Quick Reference Guide

90387
EOB NUMBER

EOB DESCRIPTION
Claim/service lacks information or has submission/billing error(s): Missing/incomplete/invalid beginning and ending dates of the period billed.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The date of service on the billed service line is not within the dates for the covered period. Correct and resubmit for reconsideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90912
EOB NUMBER

EOB DESCRIPTION
The attachment/other documentation that was received was the incorrect attachment/document: Secondary payment cannot be considered without the identity of or payment information from the primary payer.

ADDITIONAL STEPS
This EOB denial is specific to the DFEC, DEEOIC, and DCMWC programs.

The Carrier Form was submitted without the OWCP 1500 or UB-04 form from the provider that performed the service. Resubmit the bill with the appropriate claim form for consideration.

Return to EOB List

Explanation of Benefits Number
Quick Reference Guide

90970
EOB NUMBER

EOB DESCRIPTION
Insufficient treatment records for the treatment bills.

ADDITIONAL STEPS
This EOB denial is specific to the DCMWC program.

The Treatment bill was submitted without an attachment. Resubmit with supporting documentation.

Refer to the DCMWC Procedure Manual for additional information

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Explanation of Benefits Number
Quick Reference Guide

90974
EOB NUMBER

EOB DESCRIPTION
Associated DME authorization is available for supply/accessories.

ADDITIONAL STEPS
This EOB denial is specific to the DEEOIC program.

The associated DME authorization is available for supply or accessories. Correct and resubmit the bill for reconsideration.

Return to EOB List