

EOB Code	Description	Explanation and Steps
005	Inpatient / Outpatient Conflict	An outpatient and an inpatient claim, billed by the same hospital, occur within 24 hours of each other. Determine if the claims are for the same diagnosis, and did occur within 24 hours of each other. If so, the claims must be combined together on a single claim and billed as inpatient services. If the claims are for different diagnoses, please contact Provider Relations at 1-800-251-1268 to have the claims reviewed.
011	Invalid Procedure Modifier	A line item can have up to four modifiers. One or more of the line item modifiers is not valid for an OPSS claim. The hospital may have the modifier(s) removed or changed by submitting an adjustment. The list of modifiers allowed for outpatient hospital claims may be found on the EqualityCare website.
018	First DOS After Last DOS	The first date of service is after the last date of service.
025	Type of Bill/Claim Conflict	The bill type is not a valid combination of numbers. The hospital may resubmit the claim with an appropriate, valid bill type.
029	Missing/Invalid Patient Status	The patient status code is missing (blank) or invalid. If there is a status code listed, verify that it is a valid code. If it is not valid, the hospital will need to use one of the valid status codes and resubmit the claim. NOTE: Effective October 1, 2005, patient status codes 9, 40, 41 and 42 are only valid on inpatient and outpatient crossovers.
031	DOS After Claim Received	The date of service is after the date on which the claim was received.
053	Lab revenue code requires CPT/HCPCS code	If the revenue code is 300-319, 923 or 925, then the procedure code must be 36415, 36416, 80000-89999, or a HCPCS code beginning with G, P, or Q. If the procedure code is not one of these, the hospital may either change it or select a different revenue code that is more appropriate for the procedure code. To change either the procedure code or revenue code, the hospital may submit an adjustment.
110	Span Dates Not Allowed	For critical access and general hospitals, the first and last date of service on the line must be the same. Span dates are not allowed on the line for these providers' outpatient claims. The hospital will need to break out each date of service onto a separate line.
153	G0378 or G0379 Requires Bill Types 13X or 85X	The hospital billed procedure code G0378 or G0379 on a claim without bill type 13X or 85X. The provider will need to adjust the claim to either correct the bill type or change procedure code G0378 or G0379.
198	Units greater than one for bilateral procedure billed with modifier 50	The provider has used modifier 50, and the units are greater than one. The provider will need to adjust the claim to either correct the units to one or remove or change the modifier.

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212	ER revenue code requires CPT/HCPCS code	If the revenue code is 450-459, then the procedure code must be 10000-36414, 36416-69999, 90780-90799, 91123, 92002-92020, 92502-92504, 92511-92512, 92520, 92531-92534, 92541-92548, 92700, 92950-92961, 92973-92998, 96567-96999, 99170, 99185-99186, 99201-99215, 99241-99245, 99271-99292, 99431-99432, or a HCPCS code beginning with C, G, or Q. If the procedure code is not one of these, the hospital may either change it or select a different revenue code that is more appropriate for the procedure code. To change either the procedure code or revenue code, the hospital may submit an adjustment.
219	Incorrect billing of Modifier FB or FC	Modifier FB or FC is present and procedure code status indicator is not S, T, V or X. Provider can submit an adjustment to change or remove the modifier, or change or remove the procedure code.
222	Trauma response on critical care code without revenue code 068X and CPT 99291	Trauma response critical care code is present without revenue code 068X and CPT code 99291 on the same date of service. The provider can submit an adjustment to add the required missing charges, or remove the Trauma response code if appropriate.
250	Terminated Procedure	Modifier 52 or 73 was billed with an independent or conditional bilateral procedure OR a procedure with units greater than 1. The provider may submit an adjustment to correct the modifier, procedure code or units.
288	Radiopharmaceutical is Missing	Claims with nuclear medicine procedures must also contain a procedure code for a diagnostic radiopharmaceutical. The provider may submit an an adjustment to have a diagnostic radiopharmaceutical procedure code added to the claim.
330	Line Item DOS Not Within Covered Dates	The line item date of service is not within the covered dates. Correct the date of service and resubmit.
508	Surgery revenue code requires CPT/HCPCS code	If the revenue code is 360-369, then the procedure code must be 10000-36414, 36416-69999, 90780-90799, 92950-92961, 92973-92998, 95830, 96567-96999, 99170, 99185-99186, 99291-99292, 99440, or a HCPCS code beginning with C, G, or Q. If the procedure code is not one of these, the hospital may either change it or select a different revenue code that is more appropriate for the procedure code. To change either the procedure code or revenue code, the hospital may submit an adjustment.
509	Radiology revenue code requires CPT/HCPCS code	If the revenue code is 320-342, 349-359, 400-409 or 610-619, then the procedure code must be 70000-79999, 10022, 19102-19103, 27096, 47000-49491, 96400-96450, J1457, Q0092, R0070, R0075, or a HCPCS code beginning with A, C, or G. If the procedure code is not one of these, the hospital may either change it or select a different revenue code that is more appropriate for the procedure code. To change either the procedure code or revenue code, the hospital may submit an adjustment.

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657	Invalid diagnosis code or missing principal diagnosis code	The principal diagnosis field is blank or one of the diagnosis codes is missing a required fourth or fifth digit (according to the national ICD-9-CM manual). If the principal diagnosis code is present, then one of the diagnosis codes is missing a required fourth or fifth digit. The hospital should consult the current version of the ICD-9-CM manual to determine which diagnosis code is in error. The hospital may then correct and resubmit the claim.
658	Invalid procedure code	The procedure code is invalid. The hospital may submit an adjustment to have the procedure code changed. For the full list of services covered by EqualityCare in an outpatient hospital setting, the hospital may consult the APC-based fee schedule found on the EqualityCare website.
659 *	Multiple exclusive bilateral procedures w/o modifier 50	The same bilateral procedure occurs two or more times on the same date of service without modifier 50. Either the hospital meant to bill the second occurrence of the same bilateral procedure on a different date of service or the hospital billed the bilateral procedure incorrectly. When a procedure is performed bilaterally, it is billed on one line with modifier 50. If the bilateral procedure was billed incorrectly, the hospital may submit an adjustment to have the claim corrected. (Only valid for DOS prior to 10/1/05).
660	Multiple exclusive bilateral procedures w/ modifier 50	The same bilateral procedure occurs two or more times on the same date of service, some with modifier 50 and some without. Either the hospital meant to bill the second occurrence of the same bilateral procedure on a different date of service or the hospital billed the bilateral procedure incorrectly. When a procedure is performed bilaterally, it is billed on one line with modifier 50. If the bilateral procedure was billed incorrectly, the hospital may submit an adjustment to have the claim corrected.
661	Inpatient-only procedure	The procedure code can only be billed in an inpatient setting. The only exception is if the patient died in an outpatient hospital setting while the procedure was being performed. If the patient did die during the procedure, the hospital may add modifier CA (death in an outpatient hospital setting) to the line and resubmit the claim. If the patient did not die, but the doctor admitted the patient to the hospital as inpatient, then the hospital may resubmit the claim as an inpatient claim. [Please Note: In order to be paid as inpatient, the claim must include a room and board revenue code and an inpatient bill type.] The full list of inpatient-only procedure codes may be found on the EqualityCare website.
662	Mutually exclusive procedures - not payable	The procedure code is considered to be part of (or cannot be billed with) another procedure code on the claim. Unless the hospital submits an adjustment to have the procedure code changed, the line will continue to deny.
663	Modifier 25 required	Modifier 25 is required when an Evaluation and Management (E/M) procedure code, status indicator V, occurs on the same date of service as a procedure code with a status indicator of S or T. The hospital may submit an adjustment to have modifier 25 added to the line.

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664	Invalid procedure code modifier	The procedure code modifier is not valid (or not valid with the procedure code). The hospital may submit an adjustment to have the modifier removed or changed to a different modifier. The full list of modifiers allowed for outpatient hospital services may be found on the EqualityCare website.
665	All lines items are packaged	All services on the claim are packaged (assigned status indicator N) or the claim consists entirely of a combination of lines that are denied or rejected. The hospital may have left off line items or forgotten to bill procedure codes with revenue codes. If so, the hospital may correct and resubmit the claim. If not, the claim was processed correctly and will continue to deny unless additional services with a status indicator other than N are added to the claim. The status indicator assigned to each procedure code may be found on the APC-based fee schedule posted to the EqualityCare website.
666	Procedure code is assigned Status Indicator H and no procedures with Status Indicators S, T or X are present on the claim	The procedure code is assigned status indicator H or APC 00987-00997 (implant), and no other procedure code with a status indicator of S, T or X is present on the same date of service. The hospital may submit an adjustment to have a procedure code with a status indicator of S, T or X added to the claim. To find a procedure code with a status indicator of S, T or X, the hospital may consult the APC-based fee schedule found on the EqualityCare website.
667	Mutually exclusive procedures - payable w/ appropriate modifier	The procedure code is considered to be a part of (or is not normally billed with) another procedure code on the claim. The hospital should first evaluate the appropriateness of the procedure codes billed. If the procedure codes are appropriate, the hospital may submit an adjustment to have a modifier added or changed. The modifier must be applicable to the procedure code and be an approved OPPTS modifier. The list of modifiers allowed for outpatient hospital services may be found on the EqualityCare website.
668	Multiple medical visits occur on the same day	Multiple units were billed for the same medical visit. For example, if procedure code 99215 (outpatient visit) is billed with 2 or more units, the line is denied with EOB code 668. If the medical visits were distinct and independent of each other, the hospital may submit an adjustment to have condition code G0 added to the claim.
669	Blood transfusion or exchange billed w/o blood product	The procedure code is for a blood transfusion or exchange, but a blood product procedure code is not present on the claim. The hospital may submit an adjustment to have a blood product procedure code added. For the full list of services covered by EqualityCare in an outpatient hospital setting, the hospital may consult the APC-based fee schedule found on the EqualityCare website.

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670 *	Observation does not meet minimum hours, qualifying diagnosis, and/or T procedure conditions	The procedure code is G0244 and the units are less than 8; OR the principal or admitting diagnosis code does not indicate congestive heart failure, asthma or chest pain; OR a procedure code assigned Status Indicator T occurs on the same or previous date of service. First, check the units billed. To use G0244, an eight hour minimum is required (8 units, where 1 unit = 1 hour). Next check the principal and admitting diagnosis codes against the list of diagnosis codes found on the EqualityCare website for congestive heart failure, asthma and chest pain. To use G0244, the principal or admitting diagnosis code must be one from the list. Finally, check the other procedure codes on the claim to see what Status Indicators were assigned. To use G0244, a procedure code with Status Indicator T cannot be billed on the same or previous date of service (except for procedure code 90780). The hospital may submit an adjustment to have the claim or line corrected.
671	Multiple codes for the same service.	Codes which indicate the same service are billed on two different lines with two different codes. The following pairs of codes will trigger this edit: C1012 / P9033, C1013 / P9031, or C1014 / P9035. The provider can submit an adjustment to remove one of the duplicating codes.
672 *	E/M condition not met and line item date for observation code G0244 is not 12/31 or 1/1	There is no E/M visit the day of or the day preceding the observaion and the date of observation is not 12/31 or 1/1 of any given year. The provider can submit an adjustment to add the appropriate E/M code.
673	E/M condition not met for separately payable observation and line item date for code G0378 is 1/1	There is no E/M or critical care visit the day of or the day preceding the observation OR code G0379 is missing AND the date of observation is 1/1 of any given year. The provider can submit an adjustment to add the appropriate E/M code.
674	Procedure code G0263 billed w/o procedure code G0244	Procedure code G0379 was billed without procedure code G0378; OR procedure code G0378 was billed with G0379, but an error occurred with the line with G0378. If procedure code G0378 is missing, the hospital may submit an adjustment to have it added to the claim. If procedure code G0378 is present, then determine which other EOB code is posting to that line and then refer to the instructions for that EOB.
675	Inappropriate use of modifier CA	An inpatient-only procedure may have only 1 unit if it is billed with modifier CA. Also, only 1 inpatient-only procedure per claim may have modifier CA. Since it is likely the entire claim denied, the hospital may correct the claim and resubmit it.
676	Date of service is too far into the past or future	A header or line date of service may be too far into the future or past to be processed. Verify the dates of service were keyed correctly. This EOB means the entire claim denied, so the hospital may correct the date of service and resubmit the claim.

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677	A date of service exception posted to the claim header and/or line	The coverage period and line dates of service must be valid for an outpatient hospital claim to be processed. If even one date of service error occurs with the coverage period or a line, the entire claim is denied. Look for EOB 016 (missing dos), 018 (last dos less than first dos), 031 (last dos greater than batch date), 330 (line first or last dos is not within header dos) or 110 (line first dos and last dos are not equal). One or more of these EOBs describe what caused the claim to deny. The hospital may correct the error(s) and resubmit the claim.
678	Invalid condition code/bill type combination	Condition code 41 (partial hospitalization) is not valid with bill types 12X and 14X. Also, EqualityCare does not cover partial hospitalizations in the outpatient setting.
679	CA modifier requires patient status code 20	Modifier CA was billed with an inpatient-only procedure and patient status code 20 is missing. The hospital may have the patient status code changed by submitting an adjustment.
680	Claim lacks required device code	Surgical procedure codes that involve the implantation of a device (e.g., a pacemaker) must be billed with the device code. The hospital may submit an adjustment to have the device code added to the claim or add an appropriate modifier (52, 73, or 74).
681	DME is not implantable	Durable medical equipment (DME) that is not implantable is not covered in an outpatient hospital setting. Unless an adjustment is submitted to have the procedure code changed, the line will continue to deny.
682	Claim contains an inpatient only procedure	The claim contains a procedure that EqualityCare has determined can only be performed in an inpatient setting. Look for the line posting EOB 661. This line contains the inpatient-only procedure. For further instructions, refer to EOB 661 above.
683	Invalid procedure code or invalid revenue code w/o procedure code	The procedure code is invalid or the revenue code is invalid and does not have a procedure code. The hospital may submit an adjustment to have the procedure code or revenue code changed.
684	Procedure code not allowed for the provider taxonomy	The procedure code cannot be billed by general or critical access hospitals in an outpatient setting. The hospital may submit an adjustment to have the procedure code changed. The procedure code must be appropriate for the revenue code (see EOB 053, 508, 509 and 212). For the full list of services covered by EqualityCare in an outpatient hospital setting, the hospital may consult the APC-based fee schedule found on the EqualityCare website.
685	Revenue code not allowed for the provider taxonomy	The revenue code cannot be billed by general or critical access hospitals in an outpatient setting. The hospital may submit an adjustment to have the revenue code changed. The revenue code selected must be appropriate for the procedure code (see EOB 053, 508, 509 and 212).

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686	Revenue code not covered for date of service or is invalid	The revenue code is not covered for the date of service or is invalid. The hospital may have the revenue code or line date of service changed by submitting an adjustment. If the revenue code is changed, it must be appropriate for the procedure code (see EOB 053, 508, 509 and 212).
687	Incorrect billing of blood and blood products	If the provider bills revenue code 38X, then the claim must contain revenue code 39X. If revenue codes 38X and 39X occur on the same date of service, then both lines must have modifier BL, and the procedure code and units must match.
688	The service is classified as partial hospitalization	The status indicator assigned to the procedure code is P, which indicates partial hospitalization. EqualityCare does not cover partial hospitalizations in the outpatient hospital setting. Unless an adjustment is submitted to have the procedure code changed, the line will continue to deny.
689	Invalid procedure code used with revenue code 0762	If the revenue code is 762 (observation), then the procedure code must be 99217-99220, 99234-99236, G0378 or G0379. If the procedure code is not one of these codes, the hospital may either change it or select a different revenue code that is more appropriate for the procedure code. To change either the procedure code or revenue code, the hospital may submit an adjustment.
690	Procedure occurs on the same day as an inpatient-only procedure	The procedure code occurs on the same date of service as an inpatient-only procedure. All services billed on the same day as the inpatient-only procedure are denied. For further instructions, see EOB 661.
691	Revenue code requires a procedure code	The revenue code requires a procedure code. The hospital may submit an adjustment to have a procedure code added to the line. For the full list of procedure codes covered by EqualityCare in an outpatient hospital setting or a listing of which revenue codes require procedure codes, the hospital may consult the APC-based fee schedule found on the EqualityCare website.
694	Invalid modifier for a line priced by APC-based fee	One or more of the line item modifiers is not valid for a line priced by APC-based fee. The hospital may have the modifier(s) removed or changed by submitting an adjustment. The list of modifiers allowed for outpatient hospital claims may be found on the EqualityCare website.
698	Condition Code 21 present	Condition code 21 (service submitted for verification of denial) is present on the claim. This condition code causes the entire claim to deny. The hospital may remove it and resubmit the claim.
700	Invalid bill type for OPSS claim	OPSS claims are limited to bill types 12X, 13X, 14X and 85X. Verify the correct provider number was used for the services billed. The hospital may have mistakenly billed hospice, home health or ESRD services under the wrong provider number. If the correct provider number was used, then the provider may correct the bill type and resubmit the claim.

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