

BlueCard and Federal Employee Program Remittance Advice Code Descriptions

The following remittance explanation codes and descriptions reflect those found on **hardcopy (paper)** BlueCard® or Federal Employee Program (FEP) remittance advices. These same codes and descriptions will also apply to online BlueCard and FEP remittance advices, available on BlueAccess, the secure area of www.bcbst.com.

Although the provider action/information column does not appear on the remittance advice, we have included it on this document to assist you.

Note: When an entire FEP claim is denied, it will not appear on the provider's remittance advice with one of these codes. Instead a separate Explanation of Payment will be issued to the provider with a complete explanation.

Explanation Code <i>(Used on paper remit)</i>	Description	Provider Action/Information (NAR=No Action Required)
01	Patient's coverage was not in effect at the time of this service.	NAR
02	Charges for a pre-existing condition are not eligible for benefits.	NAR
03	Benefits cannot be determined until payment of premium is received.	If the Home Plan receives the premium payment, the claim will be reprocessed.
04	This dependent is not eligible for benefits.	NAR
05	Benefits are excluded for on-the-job injuries or for services eligible for Workmen Compensation benefits.	Contact the member's employer about filing a Workman's Compensation claim.
06	This service is not considered an eligible expense under patient's coverage.	NAR
07	This charge was processed on a previous claim.	Refer to previous remittance advices for the original payment information. Providers can review paper copies or search online remits available through BlueAccess, the secure area of the BlueCross BlueShield of Tennessee Web site, www.bcbst.com . Remittance advices remain online for 18 months.
08	This charge exceeds the maximum allowable under patient's coverage.	NAR
10	Routine examinations are not eligible for benefits.	NAR
11	Personal items cannot be considered for benefits.	NAR
12	No benefits are available for a cosmetic surgery charge.	NAR

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13	Ineligible Place of Service - Ineligible place of service for the procedure performed.	Submit corrected bill, if appropriate.
14	This charge is for drugs which may be purchased without a prescription.	NAR
15	Routine nursery or pediatric care of a newborn is not eligible for benefits.	NAR
16	This dental service is not eligible for benefits under patient's coverage.	NAR
17	Patient's Gender Ineligible - The service performed is ineligible for the patient's gender.	Submit corrected bill, if appropriate.
18	To expedite processing of your claim, we have split the charges into more than one claim.	NAR
19	The provider of this service is not an eligible provider of services as defined by the patient's coverage.	NAR
20	Maximum benefits payable have been provided.	NAR
21	Payment adjusted because new patient qualifications were not met.	NAR. Claim records indicate this is not a new patient.
22	Benefits cannot be provided for services which are not considered medically necessary.	NAR
23	Benefits cannot be provided for the condition causing this service.	NAR
24	Late discharge fees are not eligible for benefits.	NAR
25	These charges exceed the maximum room and board allowance for patient's coverage.	NAR

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26	Benefits are not available for hospitalizations primarily for Testing, X-ray, Laboratory, Physical Therapy, or Diagnostic Evaluations.	NAR
27	Physician fees are to be filed separately, not as part of the hospital claim.	Submit physician's fees on a CMS-1500 paper claim or ANSI-835P electronic claim.
29	Patient's coverage does not provide benefits for hospital visits during surgical confinement.	NAR
30	Outpatient or emergency room treatment not performed within your coverage limits.	NAR. The member's health benefits plan has limits on these services.
31	Processing has been suspended until we receive additional information needed to complete our review of this claim.	NAR - unless the provider receives a letter specifically requesting additional information. This code may be issued when additional information is needed from the treating provider, another provider or from the member.
32	These charges should be filed separately, not as part of the hospital claim.	Submit physician's fees on a CMS-1500 paper claim or ANSI-835P electronic claim.
33	This payment was secondary to primary benefits provided by patient's other health insurance coverage.	NAR
34	This payment was secondary to benefits provided by patient's Medicare.	NAR
35	To determine benefits, we need a copy of the Medicare Summary Notice (MSN).	Resubmit claim with a copy of the MSN for these services.
36	This is an adjustment to a previously processed claim.	NAR
37	Referral/Pre-authorization exceeded.	NAR
38	The pre-existing exclusion will not be investigated until you have exceeded your deductible.	NAR

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39	No benefits are available for experimental/investigative procedures.	NAR
40	We are unable to process your claim because we lack information concerning your other insurance coverage.	NAR. The member must respond with information on other insurance before a claim can be processed.
41	Your claim cannot be processed without a copy of the EOB from the patient's other coverage. After the EOB is received, we will reconsider the charges.	Resubmit claim with a copy of the member's Explanation of Benefits (EOB) from the primary insurer.
44	Benefits have been reduced due to non-compliance with the provisions of the Mandatory Ambulatory Surgery Program.	NAR. The member's health benefits plan may specify where certain services can be performed to be considered covered services. Providers should be notified of such requirements when calling to verify benefits.
45	Benefits have been reduced due to non-compliance with the provisions of the Mandatory Second Opinion Surgery Program.	NAR. The member's health benefits plan may require a second opinion before certain services can be considered covered services. Providers should be notified of such requirements when calling to verify benefits.
46	Because a non-participating provider was used, benefits have been reduced.	NAR
47	Claim/service not covered/reduced because alternative services were available and should have been utilized.	NAR
48	Benefits have been reduced due to non-compliance with the provisions of the Pre-Admission Certification Program.	NAR. The member's health benefits plan may require a prior authorization before certain services can be considered covered services. Providers should be notified of such requirements when calling to verify benefits.
49	An intermediary handles this service. The claim should be filed to the intermediary.	NAR. The provider should be advised that the service is handled by another carrier when calling for verify benefits.
52	Home Plan will handle direct from the original claim filed. Please contact the Home Plan if additional information is needed.	Contact the Home Plan by using the telephone number on the back of the member's ID card.
53	Invalid Identification number.	Submit corrected bill with member's correct ID numbers, if appropriate.

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55	Services not covered because the patient is enrolled in a hospice.	NAR
56	Exceeded time limit for filing claims.	NAR
57	Services rendered in non-participating facility.	NAR
58	Exceeded contract liability/services rendered in non-participating facility.	NAR
59	These charges exceed the maximum per diem allowance for patient's coverage.	NAR
60	Payment adjusted because transportation is only covered to the closest facility that can provide necessary care.	NAR
61	Charges denied Community Mental Health Center.	NAR
62	A surgical CPT4 procedure code is required for all outpatient surgery facility claims.	Resubmit claim with appropriate CPT [®] code(s).
63	Services not documented in patient's medical records.	NAR
64	Charge exceeds the all inclusive/contracted allowable for this service(s).	NAR
69	Invalid CPT [®] code and/or modifier combinations.	Submit corrected bill, if appropriate.
72	Claim/service denied. Appeal procedures not followed or time limits not met.	NAR
76	Payment denied because service/procedure was provided outside the United States or as a result of war.	NAR
80	Other insurance inquiry letter has been sent to the subscriber.	NAR. The member must respond with information on other insurance before a claim can be processed.

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84	To determine benefits, we need a copy of the original Medicare Explanation of Benefits (EOB) showing the approved amounts.	Resubmit claim with a copy of the member's Medicare EOB showing the approved amounts.
88	Exceeded the Age Limit - The patient has exceeded the age limit for these services.	NAR
90	Not covered unless the provider accepts assignment.	NAR
97	Home Plan Handle Direct - Charges are not eligible under this line of business. The Home Plan will handle direct.	NAR
98	FEP OBRA 93 pricing	NAR. The patient is over 65 and not enrolled in Medicare Part B. Federal Law prohibits payment to a Medicare Participating Provider exceeding the Medicare Participating Allowance.
99	FEP NPA pricing	NAR. This is the allowance for non-participating providers as determined by the member's Federal Employees Health Benefits Program (FEHBP).