

Commercial Remittance Advice Code Descriptions

For remittance advice that reflect dates of service of May 1, 2008 and after, explanation codes used for BlueCare Tennessee will also appear in this listing.

The following remittance explanation codes and descriptions reflect those found on hardcopy (paper) Commercial remittance advice. These same codes and descriptions will also apply to online Commercial 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.

HIPAA-compliant electronic remittance advice (ANSI-835) will not use these explanation codes. The electronic remittance advice (ANSI-835) uses HIPAA-compliant remark and adjustment reason codes. Where appropriate, we have included the HIPAA-compliant remark and/or adjustment reason code that corresponds to a BlueCross BlueShield of Tennessee explanation code. Standardized descriptions for the HIPAA adjustment reason and remark codes can be accessed on the Washington Publishing Company Web site at http://www.wpc-edi.com/codes.

(Revised 12/14/2023)

Exp. Code	Text	CARC	RARC
002	This charge exceeds the maximum allowable under this member's coverage.	45	
008	This service is limited by the member's plan. Benefits were extended by our Utilization Management department.	119	
018	This charge exceeds the maximum allowable under this member's coverage	45	
01D	Processing of this claim was suspended awaiting information requested from this provider or subscriber.	133	
02D	Benefits for this service are limited to two times per contract year.	273	N435
03D	Benefits for this service are limited to one time per three-month period.	273	N435
04D	Benefits for this service are limited to one time per thirty-six month period.	273	N435
050	This charge exceeds the maximum allowable under this member's coverage.	59	N644
054	Services denied due to being delegated to another entity.	109	N418
057	We are deducting this amount because of an overpayment on a previous FSA claim.		
05D	Benefits for this service have a twelve-month waiting period.	179	
062	These expenses are not eligible since there is no money left in your Flexible Spending Account.	187	
066	This is not a covered service under medical benefits. The service is eligible under the Health Reimbursement Account.	96	N30
068	These expenses are not eligible since there is no money in your Flexible Spending Account.	187	

069	These expenses are not eligible since there is no money in your Flexible Spending Account.	187	
06D	This service was performed on a previously missing tooth.	272	
071	Your Dependent Care Flexible Spending Account funds have been exhausted. Payment may be made when additional funds are available.	187	
073	Benefits for this service are excluded under this member's plan.	96	N216
077	Long Term Care Hospital Override		
078	Claim Payment Level Override		
079	Line Item Denial Override		
07D	Benefits for this service are limited to two times per twelve-month period.	273	N412
082	Dual Secondary Processing Override		
084	UM Program ID Override		
08D	Services for hospital charges, hospital visits, and drugs are not covered.	96	N216
094	Sequestration		
09D	Services for premedication and relative analgesia are not covered.	96	N126
0DA	This is an adjustment to a previous dental claim that paid to the provider but should have paid to the subscriber.	169	
0s0	Change Secondary Coinsurance Amount		
0s1	Change Secondary Copay Amount		
104	This member's coverage excludes benefits for the condition for which this service was rendered.	96	N216
107	Claim UM Primary Line		
108	HHA NOA Exception		
109	Claim UM Primary Line Exclusion		
10D	Benefits for sealants and dietary instruction are not covered.	96	N216
11D	The procedure code and tooth number filed do not correspond. An alternate procedure code was used for pricing.	169	
12D	Benefits for this procedure are limited to once per lifetime, per tooth and tooth surface.	119	N587
13D	Appliances due to wear and services to improve bite or to correct congenital or developmental problems are non-covered.	96	N216

14D	Benefits for implants, TMJ (Temporomandibular Joint) Dysfunction and periodontal splinting are not covered.	96	N216
15D	Benefits for this service are limited to one time per three-month period.	273	N435
16D	We cannot process this claim until we receive previously requested information concerning the member's other insurance.	22	
17D	Benefits for services that are considered to be primarily cosmetic are not covered.	96	N383
17d	A portion of these services is considered primarily cosmetic and will not be covered.	96	N383
18D	This procedure is not covered, an allowance for a standard procedure was paid.	169	
19D	Benefits for this service are limited to two times per calendar year.	273	N435
1DA	This dental claim is being adjusted due to a corrected billing submitted by the provider.	169	
1DO	Temporary procedure has been deducted from the amount of the primary procedure.	169	
1s1	Secondary Supplementation Amount		
201	Interest is being recouped.	85	
20D	Relines cannot be billed separately if done within six months of the primary denture and or partial procedure.	273	N435
217	Paid Limit Accumulator Has Been Altered by Med Supp Sequestration Reduced from the Paid Amount		
21D	Benefits for this service are limited to one time per sixty-month period.	273	N435
22D	Benefits for this service have a twenty-four month waiting period.	179	
23D	These benefits have been paid by the member's medical policy.	270	
24D	Benefits for this service are limited to one time per six-month period.	273	N435
25D	This category of dental benefits has a waiting period as specified in this member's dental contract.	179	
26D	Benefits for this service are limited to one time per five-month period.	273	N435
27D	Benefits for this dental service are not available, per this member's contract.	96	N216
28D	Benefits for this service are limited to one time per twelve-month period.	273	N435
29D	Benefits for this dental service are not available, per this member's contract.	96	N216
2s2	Secondary Allow Amount		
30D	This charge is a duplicate of a previously processed claim for this member.	18	N702

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30d	This procedure is a duplicate of a previously filed procedure.	18	N522
31D	This service is denied based on information submitted. Participating dentist should charge only amount in 'Patient Owes'.	96	N10
328	This claim was adjusted to provide corrected benefits.	169	
32D	Benefits for this service are limited to one time per four-month period.	273	N435
330	Adjustment SF Pended		
331	Secondary Payor Pricing Qualifier		
33D	Benefits for this service are limited to one time per two-year period.	273	N435
341	HVA ASO Account Request	169	
342	Provider Audit	169	
343	This claim was paid to the wrong payee.	169	
344	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
345	Benefits for this service are excluded under this member's plan.	96	N30
346	Duplicate of previous claim. If corrected billing, please resubmit according to billing guidelines.	18	N702
347	Benefits for this service are excluded under this member's plan.	96	N30
348	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418
349	This claim was adjusted to provide benefits secondary to Medicare.	23	
34D	Benefits for this service have a ninety-day waiting period.	179	
350	This is a subrogation adjustment. It will not effect previously assigned patient liability.	215	
351	This claim was adjusted to provide benefits secondary to this member's other insurance coverage.	23	
352	This claim was previously processed under another member's name or ID number in error.	169	
353	This claim was previously processed under another member's name or ID number in error.	169	
354	This claim was adjusted to provide corrected benefits.	169	
355	This claim was adjusted to provide corrected benefits.	169	
356	This claim was adjusted to provide corrected benefits.	169	

35D	Benefits for this service are limited to one time per twenty-four month period.	273	N435
365	HVA Provider Audit	169	
366	This claim was adjusted to provide corrected benefits.	169	
367	This claim was adjusted due to a change in provider information.	169	
368	This claim was adjusted due to a change in provider information.	169	
369	This claim was adjusted to provide benefits secondary to Medicare.	23	
36D	These benefits were previously paid under an incorrect provider status.	170	N95
370	This claim was adjusted to provide corrected benefits.	169	
371	This claim was adjusted to provide corrected benefits.	169	
379	This is a subrogation adjustment. It will not effect previously assigned patient liability.	215	
37D	This service needs to be resubmitted using current American Dental Association procedure codes.	181	M20
37d	This service needs to be resubmitted using current American Dental Association procedure codes.	181	M20
380	This claim was adjusted to provide benefits secondary to Medicare.	23	
381	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	22	MA92
382	Fraud/Abuse Recoupment	169	
383	This claim was adjusted to provide corrected benefits.	169	
384	This claim was adjusted to provide corrected benefits.	169	
385	This claim was adjusted because we were notified that the provider billed for this service in error.	169	
389	This claim was adjusted to provide corrected benefits .	169	
38D	This service has been denied due to contract limitations.	273	N435
390	This claim was adjusted to provide corrected benefits.	169	
391	This service was previously denied as a duplicate in error.	169	
392	This claim was adjusted to provide corrected benefits.	169	
393	This claim was adjusted to provide corrected benefits.	169	

394	This claim was adjusted to provide corrected benefits.	169	
395	This claim was adjusted to provide corrected benefits.	169	
39D	Benefits for this service are limited to one time per year.	273	N435
3s3	Supplemental Calculation Method		
40D	This date of service is after this member's termination date.	27	N30
41D	This service has been paid based on group's request.		
42d	McKee Executive Dental payment reimbursement		
43D	Processing of this claim is suspended awaiting information from the provider.	163	N686
44D	This charge exceeds the maximum allowable under this member's contract.	45	
46D	Processing of this procedure is suspended awaiting information from this member's medical or other carrier's policy.	22	
47D	Benefits for adult orthodontics are only payable for TMJ diagnosis.	96	N569
48D	Benefits for this service are limited to one time per forty-eight month period.	273	N435
50D	Benefits for this service are limited to three times per twelve-month period.	273	N435
51D	Grace period for plan limits.	45	
54D	Benefits for this service are limited to one time per calendar year.	273	N435
55D	Benefits for this service are limited to once per lifetime.	273	N435
56D	Benefits for this service are limited to four times per calendar year.	273	N435
57D	Benefits for this service are limited to one time per three-year period.	96	N130
57d	Benefits for this service are limited to one time per three calendar year period.	273	N435
58D	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	22	N4
59D	Benefits for this service are limited to one time per five-year period.	273	N435
60D	The combination of x-ray charges submitted on this claim should not exceed the cost of a full mouth series.	169	
61D	This allowance is based on a less costly procedure. The disallowed amount will be the patient's responsibility.	169	
62D	The combination of x-ray charges submitted on this claim should not exceed the cost of a full mouth series.	169	

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63D	Benefits for crowns are available only when the tooth cannot be restored by any other material.	96	M25
6s6	Change Secondary Allow per Unit		
7s7	Change Secondary Allowed Units		
82D	This member or dependent is not eligible for dental benefits.		
84D	This member is not eligible for dental benefits.	96	N216
85D	This patient has met his or her annual or lifetime maximum benefits.	119	N587
86D	This patient has met his or her annual or lifetime maximum benefits.	119	N587
89D	This dental claim was processed in error.		
8s8	Change Secondary Disallow Amount		
90D	This member's contract does not allow for crown coverage. An allowance has been made for a stainless steel crown.	169	
92D	Benefits for this service are limited to three times per calendar year	273	N435
95D	Temporary partials are only covered for the anterior front teeth.	96	N130
97D	This charge is considered part of the total cost. Please do not bill separately.	169	
98D	This dental claim was processed in error.	B11	N216
9s9	Change Secondary Deductible Amount		
A01	This provider is not eligible under this member's coverage.	170	N348
A03	This is a Third Party Liability Pay and Chase Adjustment.	215	
A04	Third Party Liability Pay and Chase Adjustment	215	MA67
AB0	Call 1-800-924-7141 for claim detail if needed.		
ABT	These digital services were provided by AbleTo, a BCBST vendor partner with zero cost share for this member.		
AD3	This is a subrogation adjustment. It will not affect previously assigned patient liability.	215	
AD4	This is the disallowed amount prior to subrogation adjustment.	215	MA67
ADP	This amount was previously paid to the wrong payee. A corrected payment has been made.	169	
ADT	This is an adjustment of a previously processed claim due to a BCBST change to the provider assignment.	169	

ADX	This claim was adjusted due to a change in provider information.	169	
AMB	Services are not covered under the payer's medical plan. Contact AmeriBen for additional information.	109	
AO2	This amount includes the benefits provided by this member's other insurance carrier.	22	
APS	Payments have been suspended at the direction of the Bureau of TennCare.	В7	
ATP	Benefits for this service are excluded under this member's plan.	96	N216
AUT	Benefits cannot be provided for this service because the required authorization or notification is not on file.	197	
AY1	Outside Year Period Override		
AY8	Benefits for this service are limited to one time per eight calendar years.	273	N435
AZP	This medication is to be dispensed by CVS Specialty at 1-888-265-7990. A one time exception was allowed under your medical plan.	45	N189
B01	This procedure is not covered per contract limitations. Alternate procedure pricing was used.	169	
B02	Number of services exceeds contract limitations. An alternate procedure was used.	169	
В03	Benefits for this service are limited to one time per seven year period.	273	N435
B07	Benefits for this service are limited to two times per two-year period.	273	N435
B08	This member's coverage does not provide benefits for TMJ (Temporomandibular Joint) Dysfunction and occlusion.	96	N216
B09	This member's coverage does not provide benefits for implants and periodontal splinting.	96	N216
B10	This member's coverage does not provide benefits for basic restorative dentistry.	96	N216
B11	This member's coverage does not provide benefits for crown and prosthetic dentistry.	96	N216
B12	This member's coverage does not provide benefits for orthodontic dentistry.	96	N216
B13	This member's coverage does not provide benefits for gold foil restorations.	96	N216
B14	This member's coverage does not provide benefits for dental care that is elective or a special technique.	96	N216
B15	This member's coverage does not provide benefits for replacement services due to loss or theft.	96	N216
B16	This member's coverage does not provide benefits for desensitizing teeth.	96	N216
B17	This service is primarily considered medical. Please file with this member's medical policy.	254	
B18	This member's coverage does not provide benefits for adult orthodontics.	96	N216

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B19	This member's coverage does not provide benefits for prescribed drugs and other medications.	96	N216
B20	This member's coverage does not provide benefits for congenital, cosmetic or aesthetic services.	96	N216
B21	This member's coverage only allows for sealants on the occlusal biting surface of a tooth.	96	N216
B22	This service is primarily considered medical. Please file with this member's medical policy.	254	
B23	This provider is not eligible under this member's coverage.	185	
B24	This patient has met his or her annual or lifetime maximum benefits.	119	N587
B25	Benefits for this service have a twelve-month waiting period.	273	N435
B26	Benefits for this service have a twenty-four month waiting period.	273	N435
B27	Benefits for this service have a ninety-day waiting period.	179	
B28	This service is not covered when performed on the same day as a related procedure.	273	N435
B29	Benefits cannot be provided for a prosthetic device that replaces one or more teeth that were missing prior to the policy effective date.	96	N130
B30	This service is not covered unless specific services are performed in conjunction with or prior to this service.	96	N130
B31	This charge exceeds the maximum allowable under this member's coverage.	45	
B32	This service is not covered when performed within 90 days of another active surgical or non-surgical procedure.	273	N435
В33	Benefits cannot be provided until we receive information about this member's eligibility.	252	N375
B34	Benefits for this service are limited to one time per ten year period.		
B35	Benefits payable for this member's orthodontic treatment has been provided.	96	N130
B36	This patient has met his or her dental quarterly maximum benefits.	119	N640
B37	Benefits for this service are limited to four times per twelve-month period.	273	N435
B38	Benefits for this service are limited to four times per six month period.	273	N435
B39	Benefits for this service is limited to one time per eighty-four month period.	273	N435
B40	Benefits for this service are limited to twice per lifetime.	273	N435
B41	Submit these services to the member's Dental Plan for further consideration.	109	N418
B49	Supplemental Service may be Covered by the Member's Prepaid Flex Card.	109	N418

B50	Supplemental Service may be Covered by the Member's Prepaid Flex Card.	109	N418
B51	This service does not meet BlueCross BlueShield of Tennessee clinical criteria and will not be considered for payment.	96	N130
B52	Recementing or repairs cannot be billed separately if done within twelve months of the initial placement procedure.	273	N435
B53	A deleted procedure code was filed. This code was replaced with a current procedure code.	181	M20
B54	Recementing or repairs cannot be billed separately if done within six months of the initial placement procedure.	273	N435
B55	This is a deleted/invalid code or modifier for this date of service. The provider should submit the proper code.	182	N657
B56	Benefits for this dental service are not available because it is considered an ineligible expense.	96	N30
B59	This service is considered part of the primary procedure. Please do not bill separately.	97	N19
B61	The servicing provider has billed this claim under the incorrect patient.	96	N10
B62	This claim must be filed by the provider who actually rendered the service.	96	N32
B63	This claim was adjusted because it was previously processed under a different patient.	B13	
B64	This charge was adjusted because we were notified that the provider billed for this service in error.	96	N10
B65	This claim was paid to the wrong payee.	96	N10
B66	The dental procedure code is not valid for the date of service on the claim.	181	N56
B70	Duplicate of previous claim. If corrected billing, please resubmit according to billing guidelines.	18	N522
B72	This member has met his or her two year maximum benefit for this service.	119	
BSS	An exception was allowed. After the exception period, your provider will need to follow the benefit requirements.		
СВМ	This member's primary insurance carrier already paid this amount.	23	
CCC	The payment for this service is to reimburse the provider for patient care coordination.	24	M112
CDD	This claim is a duplicate of a previously submitted claim for this member.	18	N522
CG0	This service falls into a category that is not covered under this member's dental plan.	96	N216
CG1	This service falls into a category that is not covered under this member's dental plan.	96	N216
CG2	This service falls into a category that is not covered under this member's dental plan.	96	N216
CG3	This service falls into a category that is not covered under this member's dental plan.	96	N216

CG4 this service falls into a category that is not covered under this member's dental plan. 96 N216 CG5 This service falls into a category that is not covered under this member's dental plan. 96 N216 CM1 This charge exceeds the previous carrier's allowed amount. Provider has agreed not to bill the patient for this amount. 45 CM2 The provider has agreed to accept the amount allowed under this member's contract for this service. 133 CM3 The provider has agreed to accept the amount allowed under this member's contract for this service. 133 CM5 The provider has agreed to accept the amount allowed under this member's contract for this service. 133 CM5 The provider has agreed to accept the amount allowed under this member's contract for this service. 133 CM3 This payment was secondary to primary benefits provided by this member's other health insurance. 23 CM3 This payment was secondary to primary benefits provided by this member's other health insurance. 23 CM3 This payment was secondary to primary benefits provided by this member's other health insurance. 23 CM5 This payment was secondary to primary benefits provided by this member's other health insurance. 23 CM5 This payment was secondary to primary benefits provided by this member's other health insurance. 23 CM6 This payment was secondary to primary benefits provided by			I	
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This payment was secondary to primary benefits provided by this member's other health insurance. CO2 This amount includes the benefits provided by this member's other insurance carrier. CO3 Benefits cannot be provided until we receive previously requested information concerning this member's other insurance. CO3 This procedure is not eligible for benefits under this member's coverage because it was performed for cosmetic purposes. CR This member's coverage under this plan was not in effect on the date this service was provided. CREDIT-ADJUSTIMENT-OVERPAYMENT TO BE DEDUCTED FROM PAID AMOUNT. Message appears on RA when auto deduct of overpayment. CVX Coverage Exclusion CREDIT-ADJUSTIMENT-OVERPAYMENT TO BE DEDUCTED FROM PAID AMOUNT. Message appears on RA when auto deduct of overpayment. CVX Coverage Exclusion D1 The dental allowable amount was increased. D2 The dental allowable amount per unit was increased. D3 The dental allowable amount per unit was decreased. D4 The dental allowable amount per unit was decreased. D5 The dental allowable units were increased. D6 The dental allowable units were increased. D7 The dental allowable units were decreased. D7 The dental allowable units were decreased. D8 The dental allowable units were decreased. D8 This is the dental disallowed amount. D8 Please submit the date orthodontic treatment started. D8 Please submit the date orthodontic treatment started. D8 This is the dental claim is being adjusted since we have been notified that the provider billed for this service in error. D8 This is laim was previously paid to the wrong provider. A payment has been made to the correct provider. D8 This is laim was previously processed correctly under another 10 number or patient's name. No additional payment is due.	CM2	The provider has agreed to accept the amount allowed under this member's contract for this service.	131	
This amount includes the benefits provided by this member's other insurance carrier. CDB Benefits cannot be provided until we receive previously requested information concerning this member's other insurance. CDS This procedure is not eligible for benefits under this member's coverage because it was performed for cosmetic purposes. CR This member's coverage under this plan was not in effect on the date this service was provided. CRT CREDIT-ADJUSTMENT-OVERPAYMENT TO BE DEDUCTED FROM PAID AMOUNT. Message appears on RA when auto deduct of overpayment. CVX Coverage Exclusion D1 The dental allowable amount was increased. D1 The dental allowable amount was increased. D1 The dental allowable amount per unit was decreased. D1 The dental allowable amount per unit was decreased. D1 The dental allowable amount per unit was decreased. D1 The dental allowable units were increased. D1 The dental allowable units were increased. D1 The dental allowable units were increased. D1 The dental allowable units were decreased. D2 This is the dental disallowed amount. D3 N130 D4 Please submit the date orthodontic treatment started. D3 N130 D6 This claim is being adjusted since we have been notified that the provider billed for this service in error. D1 This claim was previously paid to the wrong provider. A payment has been made to the correct provider. D3 This claim was previously processed correctly under another ID number or patient's name. No additional payment is due.	CMS	The provider has agreed to accept the amount allowed under this member's contract for this service.	131	
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	DA1	This claim was previously paid to the wrong provider. A payment has been made to the correct provider.	169	
DA3 This disallowed amount is the ortho extended treatment and has been moved to another claim. 172	DA2	This claim was previously processed correctly under another ID number or patient's name. No additional payment is due.	169	
	DA3	This disallowed amount is the ortho extended treatment and has been moved to another claim.	172	

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DA4	This is an adjustment to a previous dental claim that paid to the subscriber but should have paid to the provider.	169	
DA6	A dental adjustment is in process for this claim, which will be reprocessed on a future date.	169	
DA7	This is an adjustment to a previously paid dental claim. The payable amount is less than the amount originally paid.	169	
DA8	This is money reimbursed due to another party's payment. Refer to Patient Owes column for any liability charges.	215	
DA9	This dental claim was previously processed with an incorrect date of service.	169	
DAC	Other insurance information has been received and this member's records updated. This claim has been adjusted.	169	
DAD	Full or partial dental benefits were denied in error.	169	
DAL	This is a dental adjustment. The provider was corrected and or subscriber payment liability.	169	
DAP	The originally submitted procedure was replaced due to benefit plan restrictions.	169	
DB0	This dental claim has been adjusted due to an incorrect tooth and or surface.	169	
DB1	This dental claim was adjusted due to an incorrect procedure code.	169	
DB2	This claim was denied for an Explanation of Benefits.		
DB3	This claim paid secondary to another insurance carrier.		
DB4	This dental claim was denied requesting additional information from the provider.		
DB5	A dental adjustment has been completed and has resulted in a statistical change.	169	
DB6	This claim was adjusted because the member's eligibility has been updated.	169	
DEN	This dental service is not eligible for benefits under this member's coverage.	96	N216
DG2	The allowable is a discounted DRG amount.	45	
DIS	This charge exceeds the maximum allowable under this member's coverage.	45	
DMD	This oral surgery service does not meet the requirements of this member's program for coverage.	96	N216
DOP	We are deducting this amount because of an overpayment on a previous claim.	172	
DP0	This patient's age is not within the normal range established for this dental procedure.	96	N130
DP1	This dental procedure is not a covered service for this tooth/teeth numbers.	96	N130
DP2	The charge or number of occurrences this procedure was performed has exceeded the contract limits.	273	N435

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DP3	The charge or number of occurrences this procedure was performed has exceeded the contract limits.	273	N435
DP4	The charge or number of occurrences this procedure was performed has exceeded the contract limits.	273	N435
DP5	The number of occurrences this procedure was performed has exceeded the contract limits.	273	N435
DPX	Your group's contract requires a period of membership before benefits are available for this service.	51	N607
DRC	The dental runout time limit has been exceeded.	29	
DRE	This claim is prior to effective date of the coverage.	26	N30
DRQ	This date of service is after the termination of coverage.	27	N30
DRT	Timely filing has been exceeded.	29	
DSR	Your claim has been received and is currently under special review.	133	
DUP	Duplicate of previous claim. If corrected billing, please resubmit according to billing guidelines.	18	N522
E01	The member's contract does not cover services for this provider specialty.	170	N348
E02	The member's contract does not cover services for this provider specialty.	170	N348
ECT	ECT single or multiple is not a billable service for this discipline level.	185	N684
EMR	This amount was previously reimbursed and is not included in the Executive Medical Reimbursement.	96	M86
EMr	This amount is for Executive Medical Reimbursement.	96	M86
ЕОВ	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	22	MA04
EXC	This claim was paid as an exception. Future claims without a referral from the member's PCP will be denied.	45	N189
F01	This procedure is not eligible for benefits under this member's coverage because it was performed for cosmetic purposes.	96	N383
FAP	Advanced care planning is not covered unless part of covered hospice treatment plan. Patient is responsible for all charges.	96	N143
FBA	Applied Behavior Analysis not covered when performed as part of an educational program.	58	
FCM	This requires Case Management approval prior to rendering services.	197	
FDN	Charges exceed the Standard Option Dental fee schedule allowance and are only covered when related to an accidental injury.	96	N130
FE1	Benefits are not paid for services provided in or by a school, halfway house or by a member of its staff.	58	
FE2	Benefit maximum of one year of sperm/egg storage for latrogenic infertility has been met.	119	N587

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FEB	Please provide a revenue code that specifies the level of infant care provided.	96	N180
FED	Service is not covered unless obtained from a retail pharmacy.	96	N130
FEF	Service is not covered unless obtained from a retail pharmacy or Mail Service Drug program.	96	N130
FEL	Benefits not provided for deluxe lens features that are not medically necessary.	96	N30
FEM	Benefits not provided unless service is rendered in a Preferred facility with a Medicare Approved Transplant Program.	171	
FGE	This service is not normally performed for members in this age range.	6	N129
FGT	Member responsibility is limited on the difference between the allowed amount and this non-participating provider's billed amount.	45	
FHR	Benefits are provided for hearing aids, hearing aid dispensing fees, and supplies are limited to \$2500 every five calendar years.	119	N640
FHS	Benefits are provided for hearing aids every five calendar years.	119	N417
FID	Patient cannot be identified as our insured based on the identification information billed on the claim.	31	
FIM	Submit Itemized bill on provider letterhead, including provider name, signature, professional status, and patient information.	252	N26
FMX	The maximum lifetime benefit has been met. Please contact your Specialty Drug Pharmacy Program at 1-888-346-3731.	149	N587
FNB	Routine newborn nursery charges are not covered because the mother is not an eligible member on this plan.	96	N30
FNC	Benefits not provided for charges that are scheduled or planned but not performed.	96	N658
FPC	This service is not covered when performed in this setting.	96	N428
FPD	The procedure is considered subset or redundant to the primary procedure and is limited by this member's plan.	97	M80
FPH	This member's coverage was not in effect prior to the dates of this hospital confinement.	26	
FPX	Benefits for this charge must be determined by filing through this member's appropriate pharmacy network.	109	N418
FRC	A detailed revenue code that identifies the specific service provided during the inpatient admission is required.	226	
FRX	This prescription should be submitted to Service Benefit Plan Retail Pharmacy Program. The customer service number is 1-800-624-5060.	109	
FSR	Benefits cannot be provided until a special review is completed.	133	
FTM	Benefits are not available for the costs associated with preventive telemedicine.	96	N776
FTP	Family therapy is a non-covered service.	96	N30
FX1	Supplemental Service may be Covered by the Member's Prepaid Flex Card.	109	N418

FX2	Supplemental Service may be Covered by the Member's Prepaid Flex Card.	109	N418
FYI	RECALCULATED PAYMENT - EXCLUDED FROM AMOUNT PAID. (Message appears on RA when auto deduct of overpayment.)	103	11710
G44	This check amount is the outstanding balance (minus deductible and coinsurance) that the provider may bill.	96	N30
GAR	Execution Of Garnishment	30	1430
GLB	This claim is disallowed because it is included in the global case payment.	97	N525
GNS		109	N418
	The provider must file this claim with Magellan, P.O. BOX 5190, Columbia, MD 21046.		
GRP	The member's group has already paid for this claim. We are reimbursing the member's group by manual check.	96	N30
HLD	There is a hold on payment of this claim.	96	N30
HM0	Call 1-800-924-7141 for claim detail if needed.		
HRA	This amount was paid from the member's Health Reimbursement Account.	187	
IDN	This is a default member liability explanation code. Manual Integrated Denial Notice created with proper denial notice.	96	N216
IND	This procedure is considered investigative and is not covered under this member's plan.	55	N623
INF	Medical records have been requested from the provider.	252	M127
INH	This charge exceeds the maximum allowable under this member's coverage.	45	
INV	This procedure is considered investigative and is not covered under this member's plan.	55	N623
IPM	Individual Psychotherapy with Medical Management is non-covered.	96	N30
IRS	Execution of IRS Levy		
IS1	This is the State surcharge amount which is payable to the provider.	96	N30
ISS	This service is not covered per the information submitted. The provider should verify coding and resubmit if incorrect.	16	MA39
ITA	Benefits cannot be provided for this service because the required authorization is not on file.	197	
ITD	The provider must file this claim with his or her local BlueCross BlueShield plan for processing.	109	N418
LAB	This laboratory charge was already paid to the lab that performed the service. The patient should not be billed.	24	
LB1	This laboratory charge was already paid to this member's physician. The patient should not be billed.	24	
LDG	Benefits for Transplant Lodging/Meals are limited to \$150 a day.	119	N640

LET	Benefits cannot be provided for this service. We are sending the member additional correspondence to explain.	200	
LMX	The maximum lifetime benefits payable under this member's coverage have been provided.	119	N587
LOV	This charge exceeds the maximum allowed under this member's coverage.	45	
M09	The provider has not contracted to provide this service.	96	N448
M19	Medicare cannot process a claim submitted by a beneficiary for a COVID-19 over-the-counter test.	96	N130
M47	This is a non-covered chiropractic service.	185	N684
MAD	This portion of your Medicare Part A deductible is not covered under your supplemental policy.	96	N30
MAR	Call 1-800-924-7141 for claim detail if needed.		
MAT	A portion of this claim is denied because this member was not eligible for benefits for the entire term of the pregnancy.	179	
MBC	Benefits are not available for these services when the benefit criteria is not met.	96	N130
MBD	This member's plan does not cover the Medicare Part B deductible.	96	N30
MBX	Member has Coordination of Benefits with Other Coverage agreement. Maximum benefits have been paid by other healthcare plan or Medicare.	119	
MCC	We cannot pay benefits until this member's out-of-pocket amount has been satisfied.	96	N30
MCD	This charge was denied by Medicare and is not covered on this plan. The provider can bill the patient.	96	N30
MCV	At home COVID tests are not a reimbursable expense.	96	N130
MDC	This amount exceeds the reimbursement due to Medicaid.	45	
MDN	Submit these services to the member's Dental Plan for further consideration.	109	N418
MDT	Submit these services to the member's Dental Plan for further consideration.	109	N418
MED	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	22	MA04
MG1	Duplicate of previous claim. If corrected billing, please resubmit according to billing guidelines.	18	N522
MG2	Benefits are provided for hearing aids, hearing aid dispensing fees, and supplies are limited to \$2500 every five calendar years.	119	N640
MG3	Benefits are provided for hearing aids every five calendar years.	119	N417
MG4	Medical records have been requested from the provider.	252	M127
MG5	The provider must submit the primary diagnosis.	11	N657

MG6 This service is not covered when performed for the reported diagnosis. MG7 The charge for this service has been combined with the primary procedure. MG8 This service is not paid in addition to or separately from the primary service. MG9 The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	234 234 189	N657 M15 N20
MG8 This service is not paid in addition to or separately from the primary service.	234	
		N20
MG9 The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	189	j
		M81
MGA The provider must submit this patient's medical records. Please reference this claim number and member id when you submit the records.	252	M127
MGB Benefits cannot be provided until the provider submits a manufacturer name, product name, product number, and quantity.	252	M23
MGC The provider must submit a valid National Drug Code, units and quantity qualifier before benefits can be provided.	16	M119
MGD This service was included in the Bundled Episode Payment.	97	N525
MGE This charge is a duplicate of a previously submitted charge for this member.	18	N522
MGF The provider must submit an itemized or detailed billing before benefits can be provided for this service.	252	N26
MGG The provider must submit a description of services rendered before benefits can be provided.	252	N350
MGH The diagnosis code or procedure code is not valid for the date of service on the claim.	146	M76
MGI The service billed must be filed to Medicare.	22	
MGJ Need evidence of supervising physician or chiropractor.	16	N296
MGK The required modifier is missing or the modifier is invalid for the procedure code.	16	N823
MGL This modifier is not compatible with this procedure code. The provider should submit the proper code.	4	N519
MGM The required modifier is missing or the modifier is invalid for the procedure code.	16	N519
MGN Not a Medicare covered benefit.	96	N569
MGO This procedure is a duplicate of a previously submitted procedure.	18	N522
MGP The diagnosis submitted for this service is invalid.	16	M76
MGQ Benefits cannot be provided for this service. We are sending the member additional correspondence to explain.	200	
MLN The provider must submit the primary diagnosis.	11	N657
MPD Non-covered service. A denied predetermination is on file.	96	N30
MPF Medicare paid this service in full.	23	

MPf	Medicare paid this service in full.	23	
MR1	Medicare denied this charge and the provider cannot bill you for it.	45	
MR3	The provider agreed to accept the amount allowed under this member's contract for this service.	131	
MSD	The allowable amount for this service has been reduced according to multiple same day surgery guidelines.	59	N644
MSP	This payment is secondary to benefits provided by Medicare.	23	
MTN	This service was prepaid by Middle Tennessee IPA.	24	
MTS	Transplant related services contact the OptumHealth Managed Transplant Programs Case Management department at 800-367-4436.	109	N418
MTX	Drug not covered contact Payer Matrix at 877-305-6202.	109	N418
MVS	This member's coverage does not provide benefits for routine vision examinations.	96	N30
MVX	Routine vision services should be filed to EyeMed. Please contact EyeMed at 844-261-9034.	297	N658
MXC	The provider's charge exceeds the amount allowed by Medicare. The member is not responsible for this amount.	45	
Mds	This is a non-participating facility. The Medicare Part A deductible/coinsurance is not covered under this member's plan.	242	M115
Mrx	These benefits are reduced because a non-participating pharmacy was used.	242	
N01	This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan.	97	M80
N02	The procedure is considered subset or redundant to the primary procedure and is limited by this member's plan.	97	M80
N03	This procedure is secondary to the primary procedure and is limited by this member's plan.	97	M80
N04	This service is a part of the original surgical procedure and is limited by this member's plan.	97	M144
N05	This service is not covered when performed on the same day as a surgical procedure.	97	N20
N06	This procedure does not normally require the services of an assistant surgeon.	54	N646
N09	This procedure is not eligible for benefits under this member's coverage because it was performed for cosmetic purposes.	96	N383
N10	This procedure is considered investigative and is not a covered service under this member's plan.	55	N623
N11	This procedure is no longer considered clinically effective and is not eligible for benefits.	56	N623
N13	This is a deleted/invalid code or modifier for this date of service. The provider should submit the proper code.	182	N657
N14	This service is not covered for this member. The provider should submit the proper code or medical documentation.	16	MA39

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N15	This service is not normally performed for members in this age range.	6	N129
N16	This service is not normally performed for members in this age range.	6	N129
N17	This service is not covered when performed in this setting.	96	N428
N19	This service is not covered when performed for the reported diagnosis.	11	N657
N25	The charge for this service has been combined with the primary procedure.	234	M15
N26	This service is a part of the original surgical procedure and is limited by this member's plan.	97	M144
N29	This procedure is redundant to the primary procedure and is limited by this member's plan.	97	M80
N30	The maximum amount allowable for this equipment has been reached.	45	
NB	These benefits are for an eligible newborn who has not been added to this subscriber's plan.	96	N30
NCB	We are unable to pay claims due to a billing issue with your employer group.	96	N216
NCC	This member's coverage excludes benefits for the condition for which this service was rendered.	96	N216
NCP	Benefits for this service are excluded under this member's plan.	96	N216
NCQ	We are unable to pay claims due to a billing issue with your employer group.	96	N216
NEC	Benefits cannot be provided for services that have been determined not to be medically necessary.	50	N130
NER	Benefits cannot be provided for services not considered a medical emergency.	40	
NEX	Benefits cannot be provided for services that have been determined not to be medically necessary.	50	N130
NMP	We cannot provide benefits for services that have been determined not to be a standard medical procedure.	56	N623
NRT	This is a non-contracted room type. The room type is disallowed.	45	
025	The charge for this service has been combined with the primary procedure.	169	
OAS	This service is not normally covered for members in this age range.	6	N129
ODX	Outpatient Dialysis services for this plan is administered by Renalogic. For benefit inquiries and questions, call 1-844-242-1400.	109	
ODY	Outpatient Dialysis services for this plan is administered by Renalogic. For benefit inquiries and questions, call 800 441-4518.	109	
OJI	These services are related to an on-the-job injury.	19	
OMX	Benefits payable for this member's orthodontic treatment has been provided.		

OOA	This claim was filed by an out of area dental provider.		
ОРТ	Provider has opted out of Medicare.	185	
ОТС	Drugs that can be purchased without a prescription are not an eligible expense.	96	N30
ОТс	Drugs that can be purchased without a prescription are not an eligible expense.	96	N30
OUT	These benefits have been reduced because a non-participating provider was used.	242	N130
OVP	We are deducting this amount because of an overpayment on a previous claim.	96	N10
P59	There are one or more edits present that cause the whole claim to be rejected.	96	N56
P60	There are one or more edits present that cause the whole claim to be returned to the provider.	96	N56
P61	There are one or more edits present that cause the whole claim to be rejected.	96	N56
P62	There are one or more edits present that cause the whole claim to be denied.	96	N56
PAA	This charge exceeds the maximum allowable under this member's coverage.	45	
PAC	This charge exceeds the maximum allowable under this member's coverage.	45	
PAI	This charge exceeds the maximum allowable under this member's coverage.	45	
PAK	This charge exceeds the maximum allowable under this member's coverage.	45	
PAL	This charge exceeds the maximum allowable under this member's coverage.	45	
PAP	This charge exceeds the maximum allowable under this member's coverage.	45	
PAR	This charge exceeds the maximum allowable under this member's coverage.	45	
PAS	This provider-administered specialty medication is covered as a medical benefit.		
PCD	This charge exceeds the maximum allowable under this member's coverage.	45	
PCP	This member has not chosen a PCP or has selected a PCP who is not participating in the plan.	242	N130
PCS	This prescription requires prior authorization through your pharmacy.	197	
PDA	This charge has been reduced based on a discount arrangement with this provider.	45	
PDC	This charge has been reduced based on a discount arrangement with this provider.	45	
PDD	This charge has been reduced based on a discount arrangement with the provider of service.	45	

PDP	This charge has been reduced based on a discount arrangement with this provider.	45	
PE0	This charge exceeds the maximum allowable for this service.	45	
PEC	Capitated Entity Encounter Disallow		
PED	Routine nursery or pediatric care of a newborn is not eligible for benefits.	96	N30
PEN	Benefits for this service have been reduced due to lack of compliance with plan requirements.	197	
PEO	This charge exceeds the maximum allowable under this member's coverage.	45	
PEX	This charge exceeds the maximum allowable under this member's coverage.	45	
PFC	This charge exceeds the maximum allowable under this member's coverage.	45	
PFS	This charge exceeds the maximum allowable under this member's coverage.	45	
PFU	This charge exceeds the maximum allowable under this member's coverage.	45	
PFV	This charge exceeds the maximum allowable under this member's coverage.	45	
PFW	This charge exceeds the maximum allowable under this member's coverage.	45	
PGA	This charge is not reimbursed according to your DRG contract. Please see the provider manual.	45	
PGD	This charge exceeds the maximum allowable under this member's coverage.	45	
PGE	This charge exceeds the DRG rate for this confinement.	45	
PGO	This charge exceeds the maximum allowable under this member's coverage.	45	
PGP	This charge exceeds the maximum allowable under this member's coverage.	45	
PGR	This charge exceeds the maximum allowable under this member's coverage.	45	
PHA	Pharmacological Management is non-covered.	96	N30
PHY	Physician fees should be filed separately from the hospital claim. The provider should rebill on the proper form.	89	N200
PI	Personal items cannot be considered for benefits.	96	N30
PLC	The Medicare limiting charge was applied.	96	N30
PLP	Percent Threshold Stoploss Met	119	
PMX	This charge exceeds the maximum allowable under this member's coverage.	45	

PPD	This service is included in the ordering physician's agreement. It should be billed to the ordering physician.	24	
PRO	Professional Pricer Reduction	45	
PS	This charge exceeds the maximum allowable under this member's coverage.	45	
PS0	Benefits for this service are excluded under this member's plan.	96	N30
PS1	The maximum amount payable under this member's coverage for this service has been provided.	119	N587
PS2	The maximum number of services payable under this member's coverage has been provided.	119	N362
PS3	Drugs that can be purchased without a prescription or other non-covered drugs are excluded under this member's plan.	96	N30
PS4	Maximum benefits payable under this member's coverage have been provided.	119	N587
PS5	Benefits for this service are excluded under this member's plan.	96	N30
PSB	This charge exceeds the maximum allowable under this member's coverage.	45	
PSC	This charge exceeds the maximum allowable under this member's coverage.	45	
PSM	This charge exceeds the maximum allowable under this member's coverage.	45	
PSR	This charge exceeds the maximum allowable under this member's coverage.	45	
PSS	This charge exceeds the maximum allowable under this member's coverage.	45	
PSU	This charge exceeds the maximum allowable under this member's coverage.	45	
PSV	This charge exceeds the maximum allowable under this member's coverage.	45	
PSW	This charge exceeds the maximum allowable under this member's coverage.	45	
PTR	The maximum number of units allowed for this service under this member's coverage has been provided.	119	N362
PX	Charges for a pre-existing condition are not eligible for benefits.	51	
PXN	NetworX Std Fee Schedule	45	
RB	These charges exceed the maximum room and board allowance under this member's coverage.	78	
RDP	This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan.	97	M80
REC	MONEY RECEIVED - NO DEDUCTION FROM AMOUNT PAID. (Message appears on RA when auto recovery bypassed).		
REF	These services were provided after the time limit specified in the referral from the PCP or this member's plan.	95	N630

REJ	This convice is not covered under this member's plan	96	N30
	This service is not covered under this member's plan.		
REX	Routine examinations are not eligible for benefits under this member's plan.	49	N429
RFD	The referral for these services was denied and benefits cannot be provided under this member's plan.	16	N335
RFN	Benefits cannot be provided for these services because we have no record of a referral from this member's PCP.	16	N335
RG4	This service is not covered because it is related to this member's admission to an educational institution.	96	N30
ROU	Routine services are not covered under this member's plan.	49	N429
RPC	Charges cannot be considered if the referring provider's National Provider Identifier is not present on the claim.	16	N286
RWC	Recoup due to Subrogation/Workers Comp Third Party Liability overpayment.	215	
RWD	A risk withhold has been applied to this service. The member is not responsible for this amount.	104	
RXD	This amount was applied to your prescription deductible.	1	
RXI	Save \$\$ on drug cost. Show your BlueCross BlueShield ID card and use a member pharmacy when buying prescription drugs.	96	N30
RY1	We have paid the annual maximum allowable for these services for this member.	119	N362
RY2	The maximum days allowed for these services have been used for this member.	119	N362
S10	This member's coverage ended before the date these services were provided.	27	N30
S11	This member's coverage was not in effect on the date this service was provided.	26	N30
S12	This member's coverage was not in effect on the date these services were provided.	26	N30
S13	This member's coverage was not in effect on the date this service was provided.	26	N30
S14	This member's coverage did not take effect until after the date this service was provided.	26	N30
S16	This member's coverage was not in effect on the date this service was provided.	26	N30
S17	This member's coverage was not in effect on the date this service was provided.	27	N619
S18	Eligibility Pended for Non-Payment		
S19	This member's coverage was not in effect on the date this service was provided.	26	N30
S1A	This member's coverage was not in effect on the date this service was provided.	26	N30
S1B	This member's coverage was not in effect on the date this service was provided.	26	N30

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S1C	This member's coverage was not in effect on the date this service was provided.	27	N30
S1D	This member's coverage was not in effect on the date this service was provided.	27	N30
S1E	This member's coverage was not in effect on the date this service was provided.	27	N30
S1F	This member's coverage was not in effect on the date this service was provided.	27	N30
S 2	This member's coverage was not in effect on the date this service was provided.	14	
S20	This member's coverage was not in effect on the date these services were provided.	26	N30
S21	This member's coverage was not in effect on the date these services were provided.	26	N30
S22	This member's coverage was not in effect on the date these services were provided.	26	N30
S23	This member's coverage was not in effect on the date these services were provided.	26	N30
S24	This member's coverage was not in effect on the date these services were provided.	26	N30
S25	We have placed a hold on all claims administration for this subscriber and related members.	26	N30
S 3	This member's coverage was not in effect on the date this service was provided.	14	
S4	This member's coverage was not in effect on the date this service was provided.	27	N30
S 5	This member's eligibility does not include coverage for this type of service.	31	
S6	This member's age is beyond the limiting age for the plan.	32	N129
S61	This member is older than the plan's age limit for coverage of this service.	32	N129
S7	This member's age is beyond the limiting age for the plan.	27	N30
S8	This member's age is beyond the limiting age for the plan.	27	N30
S9	This member's coverage was not in effect on the date this service was provided.	27	N30
S?	This member was not eligible for coverage on the date this service was provided.	27	N30
SB	This patient is not a covered member under the plan.	33	
SC	This patient is not a covered member under the plan.	33	
SD	This patient is not a covered member under the plan.	33	
SDP	This service is not covered when performed on the same day as a surgical procedure.	97	N20

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SE	This patient is not a covered member under the plan.	33	
SF	This patient is not a covered member under the plan.	33	
SG	This patient is not a covered member under the plan.	33	
SH1	This charge is a duplicate of a previously processed claim.	18	N522
SHD	This charge is a duplicate of a previously submitted charge for this member.	18	N522
SL	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SL2	This charge was discounted under the provider agreement. You have saved this amount by using a participating provider.	45	
SM	This member's coverage under this plan was not in effect on the date this service was provided.	13	
SN	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SN1	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SNF	The level of care billed does not match the level authorized. The provider must submit a corrected billing.	197	
SO	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SO1	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SP	This member's coverage under this plan was not in effect on the date this service was provided.	27	N619
SPD	Supplemental Discount	45	
SPL	This patients stop-loss limit has been reached. Benefits are payable at 100%.	119	
SPT	This member's coverage has terminated.	27	N30
SQ	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
ST	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
STN	This claim is pended due to non-payment of premiums. The member should contact his or her State Group Representative.	27	N30
STP	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
STU	Benefits cannot be provided until we receive information about this member's eligibility.	252	N375
SW	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SW2	This is a non-billable service for the discipline level.	185	N684

SW3	This is a non-billable service for the discipline level.	185	N684
TF0	The claim for these services was received after the time limit specified in this member's benefit plan.	29	
TF1	The claim for these services was received after the time limit specified in the provider's agreement.	29	
TF3	The claim for these services was filed after the time limit for filing specified in this member's plan.	29	
TF4	Provider Med Supp Timely Filing Period Exceeded		
TF5	Adjustment Timely Filing Period Exceeded		
TF6	COB Timely Filing Period Exceeded		
TF7	Med Supp Timely Filing Period Exceeded		
TMF	The claim for these services was filed after the time limit for filing specified in this member's plan.	29	
TPS	Payments have been suspended at the direction of the Bureau of TennCare.	В7	
TR0	Benefits cannot be provided because there was no authorization, notification, and or referral for this service.	197	
TR1	This is not a covered service.	96	N30
TR2	The maximum amount payable under this member's coverage for this service has been provided.	119	N587
TR3	The maximum amount payable under this member's coverage for this service has been provided.	119	N587
TR4	The maximum number of services payable under this member's coverage has been provided.	119	N362
TR5	The maximum number of services payable under this member's coverage has been provided.	119	N362
TR6	The payment is reduced by the amount paid by your primary insurance carrier.	23	
Th	This member's coverage was not in effect on the date these services were provided.	26	N30
Trx	Your annual prescription drug maximum has been met.	119	N587
UAS	This member was not covered under the plan on the date this service was provided.	26	N30
UCR	This charge exceeds the maximum allowed under this member's coverage.	45	
UD	These charges have been disallowed by Utilization Management.	39	
UM0	These services were disallowed by Utilization Management.	39	
UM1	The number of services provided exceeds the number approved in the Utilization Management authorization.	198	N351

112.40		400	NO54
UM2	These services were limited by a Utilization Management authorization.	198	N351
UM3	Benefits cannot be provided because there was no authorization and/or referral for this service.	197	
VBB	An enhanced medical benefit has been applied to a service on this claim.		
VEX	This member's coverage does not provide benefits for routine vision examinations.	96	N30
VGC	This member's coverage does not provide benefits for glasses or contact lens.	96	N30
VIS	This charge exceeds the maximum allowed for vision services.	119	N587
VNC	This service is not an eligible vision expense under this member's coverage.	96	N30
VSN	Non-cover under the medical plan. If you are enrolled in a vision plan; contact your vision carrier for coverage benefits.	96	N658
VSO	This charge exceeds the maximum allowed for vision services.	119	N587
VST	Non-cover under the medical plan. If you are enrolled in a vision plan; contact your vision carrier for coverage benefits.	96	N658
W01	The maximum amount allowable for this equipment has been reached.	45	
W02	This charge is more than Medicare allows for this service. The member is not responsible for this amount.	45	
W03	Benefits cannot be provided until a special review is completed.	133	
W04	The provider must submit the NDC, drug name, RX number, strength, day supply and quantity before benefits can be provided.	16	M123
W05	The provider must submit a copy of the manufacturer's invoice before benefits can be provided.	252	M23
W06	The provider must submit the operative report or office notes before benefits can be provided.	252	M29
W07	The provider must submit a procedure code before benefits can be provided.	16	M51
W08	The information on this claim does not match the medical records submitted.	250	M127
W09	The provider has not contracted to provide this service.	96	N448
W0L	The Ambulatory Code Editor detected one or more errors for this claim line.	16	M50
W10	This procedure is not eligible for benefits when performed in a hospital setting.	96	N428
W11	A copy of the Anesthesia Flow sheet is needed to process this claim. The provider should submit this information to us.	16	N439
W12	The provider has not contracted to provide this service.	45	
W13	This service is not paid in addition to or separately from the primary service.	234	N20

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W14	This service should not be billed separately from the room and board.	234	M2
W15	This revenue code is not valid for place of service billed.	16	M50
W16	This is a non-covered service.	16	M12
W17	This service requires a detailed revenue code. The provider should refer to billing guidelines locator form 44.	16	M12
W18	This requires Case Management approval prior to rendering services.	197	
W19	The provider must submit a hard copy of this claim with outpatient medical records.	50	M127
W1L	The claim line contains revenue code 058x, 059x,0275,0276,0277,or 0278 with charges greater than zero or it has revenue code 0624.	16	M50
W1T	Benefits cannot be provided until completed consent form has been received for the Abortion, Sterilization or Hysterectomy review.	252	N3
W21	The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	189	M81
W22	This is not a valid revenue code for this provider. The provider should refer to billing guidelines.	16	M50
W23	This is an inactive revenue code. The provider should refile with a valid code.	16	M50
W24	This service requires a detailed revenue code. The provider should refer to billing guidelines locator form 42.	16	M50
W25	This revenue code is invalid for the place of service billed. The provider should verify this code.	16	M50
W26	The provider must refer to the billing guidelines for proper billing.	16	N657
W27	The facility has a separate contract for lithotripsy. When billing, the provider must use revenue code 790.	96	N56
W29	The facility did not contract for lithotripsy, revenue code 790. The provider must bill using revenue code 490 or 360.	96	N56
W2A	The provider must refer to the billing guidelines for proper billing.	96	N56
W2L	This claim contains injectable osteoporosis drugs that are not payable because the claim does not meet all of the required criteria.	50	N130
W30	This is a bundled service. The payment is included in the service to which item/service is incident.	97	M80
W31	Only the initial visit is eligible.	96	N113
W33	These charges were included in the reimbursement for the mother's room and board.	128	
W34	This is a deleted/invalid code or modifier for this date of service. The provider should submit the proper code.	182	N657
W35	These DRG outlier days were denied by Utilization Management.	69	
W36	These DRG inlier days were approved by Utilization Management.	69	

W37	This per diem rate was approved for this DRG facility transfer.	232	
W38	This amount was disallowed for this DRG facility transfer.	232	
W39	This DRG code is no longer valid.	A8	N657
W3L	This ESRD claim was billed with another bill type than 72x.	16	MA30
W40	A valid DRG code could not be assigned for the coding that was submitted. The provider must submit valid codes.	A8	N657
W41	Medical Direction of four or more concurrent procedures is not eligible for reimbursement.	B15	M80
W42	For dates of service prior to 1/1/01, please submit the claim to Magellan.	109	N418
W43	This procedure is considered investigative and is not a covered service.	55	N623
W44	Benefits cannot be provided for services that have been determined not to be medically necessary.	96	N30
W45	The claim for these services was filed after the time limit for filing specified in this member's plan.	29	
W46	The organ acquisition cost is included in the kidney transplant case rate.	97	N525
W47	This is a non-covered chiropractic service.	185	N684
W48	Benefits for maintenance or servicing of durable medical equipment within six months of purchase date are not available.	96	N30
W49	Benefits cannot be provided for this service because the required authorization or notification is not on file.	197	
W4L	ESRD claims must contain condition codes 59,71,72,73,74,76 or 80. Condition codes 73 and 74 cannot appear on the same claim.	16	M44
W50	Benefits cannot be provided for services that have been determined not to be medically necessary.	50	N130
W51	This code, modifier, or provider type is invalid. The provider should refer to billing guidelines.	96	N56
W52	The provider must submit this patient's complete medical history before benefits can be provided for this service.	252	M127
W53	This facility number is used only for Signature members. The provider must refile under the correct provider number.	16	N77
W54	The provider must submit this patient's medical records. Please reference this claim number and member id when you submit the records.	252	M127
W55	Benefits are unavailable until we receive the information we requested in a recent letter to the provider's office.	252	M143
W56	The provider must submit a letter of medical necessity and plan of treatment for this patient.	50	M135
W57	Information has been requested from another provider to completed a pre-existing review. Not action is required.	252	N204
W58	Interim bills should only be submitted once every thirty days for the same hospital stay.	16	M53

W60 Benefits cannot be provided until the provider submits a manufacturer name, product name, product number, and quantity. 252 M33 W61 This charge exceeds the maximum allowable under this member's coverage. 45 W62 This charge exceeds the maximum allowable under this member's coverage. 45 W63 The provider has agreed to waive the Medicare Part A deductible and coinsurance. 45 N364 W64 Measurement/Reporting Codes No Fee - this charge is incidental to the primary service. 97 M80 W65 This charge is more than Medicare allows for this service. The member is not responsible for this amount. 45 W66 This charge exceeds the maximum allowable under this member's coverage. 45 W67 This service is not covered since it is supplied by the government. 212 N658 W68 This service is not covered since it is supplied by the government. 212 N658 W69 This service is not covered since it is supplied by the government. 212 N658 W69 This service is not covered since it is supplied by the government. 212 N658 W60 This service is not covered since it is supplied by the government. 212 N658 W61 This service is not covered si				
W60 Benefits cannot be provided until the provider submits a manufacturer name, product name, product number, and quantity. 252 M23 W61 This charge exceeds the maximum allowable under this member's coverage. 45 W62 This charge exceeds the maximum allowable under this member's coverage. 45 W63 The provider has agreed to waive the Medicare Part A deductible and coinsurance. 45 N264 W64 Measurement/Reporting Codes No Fee - this charge is incidental to the primary service. 97 M80 W65 This charge is more than Medicare allows for this service. The member is not responsible for this amount. 45 W66 This scharge exceeds the maximum allowable under this member's coverage. 45 W67 This service is not covered since it is supplied by the government. 212 N658 W68 This service is not covered since it is supplied by the government. 212 N658 W68 This service is not covered since it is supplied by the government. 212 N658 W68 This service is not covered since it is supplied by the government. 212 N658 W68 This service is not covered since it is supplied by the government. 212 N658 W69 This service is not covered s	W59	This claim was filed under the BlueCare provider number. Please resubmit using the Commercial provider number.	16	N77
W61 This charge exceeds the maximum allowable under this member's coverage. 45 W62 This charge exceeds the maximum allowable under this member's coverage. 45 W63 The provider has agreed to walve the Medicare Part A deductible and coinsurance. 45 N364 W64 Measurement/Reporting Codes No Fee- this charge is incidental to the primary service. 97 M80 W65 This charge is more than Medicare allows for this service. The member is not responsible for this amount. 45 W66 This charge exceeds the maximum allowable under this member's coverage. 45 W67 This service is not covered since it is supplied by the government. 212 N658 W68 This service is not covered since it is supplied by the government. 212 N658 W69 This service is not covered since it is supplied by the government. 212 N658 W69 This service is not covered since it is supplied by the government. 212 N658 W60 This service is not covered since it is supplied by the government. 212 N658 W61 An ESRD claim must contain a valid weight and height passed through value codes A8 and A9. 16 N207 W70 Provider must submit the length of time the anesthetic was a	W5L	An ESRD claim must contain a diagnosis of End Stage Renal Disease.	16	M64
W62 This charge exceeds the maximum allowable under this member's coverage. 45 W63 The provider has agreed to waive the Medicare Part A deductible and coinsurance. 45 N364 W64 Measurement/Reporting Codes No Fee - this charge is incidental to the primary service. 97 M80 W65 This charge is more than Medicare allows for this service. The member is not responsible for this amount. 45 W66 This charge exceeds the maximum allowable under this member's coverage. 45 W67 This service is not covered since it is supplied by the government. 212 N658 W68 This service is not covered since it is supplied by the government. 212 N658 W69 This service is not covered since it is supplied by the government. 212 N658 W69 This service is not covered since it is supplied by the government. 212 N658 W60 This service is not covered since it is supplied by the government. 212 N658 W61 An ESRD claim must contain a valid weight and height passed through value codes A8 and A9. 16 N207 W70 Provider must submit the length of time the anesthetic was administered before benefits can be provided. 16 N203 W71 This charge exceeds the maximum allowable under this member's coverage. 45 W72 The rendering provider is n	W60	Benefits cannot be provided until the provider submits a manufacturer name, product name, product number, and quantity.	252	M23
W63 The provider has agreed to waive the Medicare Part A deductible and coinsurance. 45 N364 W64 Measurement/Reporting Codes No Fee - this charge is incidental to the primary service. 97 M80 W65 This charge is more than Medicare allows for this service. The member is not responsible for this amount. 45 W66 This charge exceeds the maximum allowable under this member's coverage. 45 W67 This service is not covered since it is supplied by the government. 212 N658 W68 This service is not covered since it is supplied by the government. 212 N658 W69 This service is not covered since it is supplied by the government. 212 N658 W60 An ESRD claim must contain a valid weight and height passed through value codes A8 and A9. 16 N207 W70 Provider must submit the length of time the anesthetic was administered before benefits can be provided. 16 N203 W71 This charge exceeds the maximum allowable under this member's coverage. 45 W72 The rendering provider is not eligible to perform the service billed. 185 N570 W73 This claim was adjusted following a provider audit. 169 W74 Medical information is needed to complete a pre-existing review. Correspondence to the provider will follow. 252 N204 W75 Thi	W61	This charge exceeds the maximum allowable under this member's coverage.	45	
W64 Measurement/Reporting Codes No Fee - this charge is incidental to the primary service. 97 M80 W65 This charge is more than Medicare allows for this service. The member is not responsible for this amount. 45 W66 This charge exceeds the maximum allowable under this member's coverage. 45 W67 This service is not covered since it is supplied by the government. 212 N658 W68 This service is not covered since it is supplied by the government. 212 N658 W69 This service is not covered since it is supplied by the government. 212 N658 W61 An ESRD claim must contain a valid weight and height passed through value codes A8 and A9. 16 N207 W70 Provider must submit the length of time the anesthetic was administered before benefits can be provided. 16 N203 W71 This charge exceeds the maximum allowable under this member's coverage. 45 W72 The rendering provider is not eligible to perform the service billed. 185 N570 W73 This claim was adjusted following a provider audit. 169 W77 W73 This charge exceeds the maximum allowable under the group practice agreement. 45 W75 This charge exceeds the maximum allowable un	W62	This charge exceeds the maximum allowable under this member's coverage.	45	
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W6L An ESRD claim must contain a valid weight and height passed through value codes A8 and A9. W70 Provider must submit the length of time the anesthetic was administered before benefits can be provided. 16 N203 W71 This charge exceeds the maximum allowable under this member's coverage. W72 The rendering provider is not eligible to perform the service billed. W73 This claim was adjusted following a provider audit. W74 Medical information is needed to complete a pre-existing review. Correspondence to the provider will follow. W75 This charge exceeds the maximum allowable under the group practice agreement. W76 This charge is included in the facility or physician fee that contracted for this service. W77 This claim was processed under continuity of care guidelines. W78 Charges do not meet qualifications for emergent/urgent care.	W68	This service is not covered since it is supplied by the government.	212	N658
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W75 This charge exceeds the maximum allowable under the group practice agreement. W76 This charge is included in the facility or physician fee that contracted for this service. W77 This claim was processed under continuity of care guidelines. W78 Charges do not meet qualifications for emergent/urgent care. 45 W80 W77 This claim was processed under continuity of care guidelines. 46 W78 Charges do not meet qualifications for emergent/urgent care.	W73	This claim was adjusted following a provider audit.	169	
W76 This charge is included in the facility or physician fee that contracted for this service. W77 This claim was processed under continuity of care guidelines. W78 Charges do not meet qualifications for emergent/urgent care.	W74	Medical information is needed to complete a pre-existing review. Correspondence to the provider will follow.	252	N204
W77 This claim was processed under continuity of care guidelines. W78 Charges do not meet qualifications for emergent/urgent care. 40	W75	This charge exceeds the maximum allowable under the group practice agreement.	45	
W78 Charges do not meet qualifications for emergent/urgent care. 40	W76	This charge is included in the facility or physician fee that contracted for this service.	234	M80
	W77	This claim was processed under continuity of care guidelines.	131	
W79 The provider must file this claim with CMS. The Medicare contractor to process this claim can be identified through the CMS website. 109 N104	W78	Charges do not meet qualifications for emergent/urgent care.	40	
	W79	The provider must file this claim with CMS. The Medicare contractor to process this claim can be identified through the CMS website.	109	N104
W7L Automated Multi-Channel Chemistry HCPCS component codes must be billed separately. 16 M126	W7L	Automated Multi-Channel Chemistry HCPCS component codes must be billed separately.	16	M126

W80	This member's benefits are based on Medicare's allowed amount.	23	
			NOSS
W8L	This ESRD claim has an invalid modifier for pricing or is missing the required combination of modifier codes	16	N823
W9L	The incorrect number of units billed for revenue code 0634 or 0635 or a dialysis code was billed with units greater than 1.	16	M53
WA0	This charge was adjusted because we were notified that the provider billed for this service in error.	96	N10
WA1	We cannot provide benefits for services that have been determined not to be a standard medical procedure.	56	N623
WA2	This claim must be filed by the provider who actually rendered the service.	96	N32
WA3	This procedure is not covered when rendered in this place of service.	96	N428
WA4	This charge exceeds the maximum allowable under this member's coverage.	45	
WA5	Benefits for this charge must be determined by filing through this member's appropriate pharmacy network.	109	N418
WA7	For dates of service prior to 1/1/01, please submit the claim to Magellan.	109	N418
WA8	The provider who rendered these services is not eligible to assist during surgery.	185	N684
WB0	A completed consent form and operative report is required from the provider before this service can be considered for benefits.	252	N3
WB1	Benefits cannot be provided until a Behavioral Health provider number and/or taxonomy code is submitted with a corrected claim.	96	N30
WB2	The provider must file this claim with Tennessee Bureau of Medicaid PO Box 460, Nashville, TN 67202-0460. 1-800-852-2683	109	N418
WB3	The provider must file this claim through the pharmacy network.	109	N418
WB4	This claim is paid according to the State Medicaid Rates due to the Deficit Reduction Act.	45	
WB5	Benefits are provided under the Vaccines for Children Program for the handling/administration of the vaccine only.	45	
WB6	Benefits can not be provided for out of network services because the required authorization is not on file.	243	M115
WB7	A completed consent form and operative report is required from the provider before this service can be considered for benefits.	252	N3
WB8	The number of administration services for these injections must equal injections billed. The provider may need to file a corrected bill.	45	
WB9	The provider must submit a valid National Drug Code, units and quantity qualifier before benefits can be provided.	16	M119
WBA	The provider must file this claim through the pharmacy network.	109	N418
WC	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418
WC1	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418

WC2 keeefts are excluded for an on the job injury or for services eligible for Worker's Compensation benefits. 19 N×18 WC5 Sentils are excluded for an on the job injury or for services eligible for Worker's Compensation benefits. 19 N×18 WD1 This service is not eligible since it was not fleed according to the corrected billing guidelines. Please submit a corrected claim. 96 N×56 WD2 We are adjusting this claim because the procedure was billed in error. 169 N×56 WD3 The provider must refer to billing guidelines for BlueCare or TennCare Select. 96 N×56 WD3 The provider must refer to billing guidelines for BlueCare or TennCare Select. 170 N×95 WD5 The provider must file this claim with Orange or Provider. The provider should refer to billing guidelines. 170 N×18 WD5 The provider must file this claim with Carelon Behavioral Health 1-88-474-0929. 109 N×18 WD7 This is not a valid revenue code for this provider. The provider should refer to billing guidelines. 16 M×50 WD8 The documentation received with this claim is not legible. Please resubmit using legible copies. 251 N×20 WE0 This claim was paid to the wrong payee. 96 N×10 WE1 This claim was paid to the wrong payee. 16 M×36 WE3 The servicing prov				1
Wind This service is not eligible since it was not filed according to the corrected billing guidelines. Please submit a corrected claim. 96 N56	WC2	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418
WD02 We are adjusting this claim because the procedure was billed in error. 169 No. WD03 The provider must refer to billing guidelines for BlucCare or TennCare Select. 96 No. WD4 This is not a valid revenue code for this type of provider. The provider should refer to billing guidelines. 170 N95 WD5 The provider must file this claim with OPTUM HEALTH SERVICES 1-855-437-3486 (1-855-tere4Th) 109 N418 WD6 The provider must file this claim with Carelon Behavioral Health 1-888-474-0929. 109 N418 WD7 This is not a valid revenue code for this provider. The provider should refer to billing guidelines. 16 M50 WB8 The documentation received with this claim is not legible. Please resubmit using legible copies. 251 N205 WB0 This service is not a covered benefit under the member's plan. 96 N30 WE1 This claim was paid to the wrong payee. 96 N10 WE2 The provider must submit Room and Board charges correctly before benefits can be provided. 16 MA30 WE3 The servicing provider has billed this claim under the incorrect patient. 16 MA30 WE3 This charge was adjusted because we were notified that the provider by service. 9	WCS	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418
W03 The provider must refer to billing guidelines for BlueCare or TennCare Select. W04 This is not a valid revenue code for this type of provider. The provider should refer to billing guidelines. W05 The provider must file this claim with OPTUM HEALTH SERVICES 1.855.437.3486 (1.855.Here4TN) W06 The provider must file this claim with Carelon Behavioral Health 1.888.474-0929. 109 N418 W07 This is not a valid revenue code for this provider. The provider should refer to billing guidelines. W08 The documentation received with this claim is not legible. Please resubmit using legible copies. W10 This is ervice is not a covered benefit under the member's plan. W10 This service is not a covered benefit under the member's plan. W10 This claim was paid to the wrong payee. W11 This claim was paid to the wrong payee. W12 The provider must submit Room and Board charges correctly before benefits can be provided. W13 The servicing provider has billed this claim under the incorrect patient. W14 This charge was adjusted because we were notified that the provider billed for this service in error. W15 This charge was adjusted because we were notified that the provider billed for this service in error. W16 This charge was adjusted because we were notified that the provider billed for this service in error. W16 This charge was adjusted because we were notified that the provider billed for this service in error. W17 This charge has been forwarded to the member's appropriate pharmacy network to determine benefits. W19 The provider has agreed to accept the amount allowed under this member's contract for this service. W19 The provider has agreed to accept the amount allowed under this member's contract for this service. W19 This service is not eligible since it was not filed according to the corrected billing guidelines. Please submit a corrected claim. W19 N429 W10 This procedure or related procedure code cannot be billed on the same or different claim within ten months.	WD1	This service is not eligible since it was not filed according to the corrected billing guidelines. Please submit a corrected claim.	96	N56
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WEL This member's coverage does not provide benefits for physical examinations and related services. WFO This service is not eligible since it was not filed according to the corrected billing guidelines. Please submit a corrected claim. 96 N180 WF1 This procedure or related procedure code cannot be billed on the same or different claim within ten months. 119 N435	WE8	Benefits have been provided at the PCP Enhancement Rate.	45	
WFO This service is not eligible since it was not filed according to the corrected billing guidelines. Please submit a corrected claim. WF1 This procedure or related procedure code cannot be billed on the same or different claim within ten months. 119 N435	WE9	The provider has agreed to accept the amount allowed under this member's contract for this service.	45	
WF1 This procedure or related procedure code cannot be billed on the same or different claim within ten months. 119 N435	WEL	This member's coverage does not provide benefits for physical examinations and related services.	49	N429
	WF0	This service is not eligible since it was not filed according to the corrected billing guidelines. Please submit a corrected claim.	96	N180
WF2 The provider must submit a valid National Provider Identifier before benefits can be provided.	WF1	This procedure or related procedure code cannot be billed on the same or different claim within ten months.	119	N435
	WF2	The provider must submit a valid National Provider Identifier before benefits can be provided.	208	

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WF4	Payment of claim is pending receipt of State of Medicaid number or Need Medicaid number and/or Disclosure Form.	16	MA112
WF5	This claim should be submitted to Department of Medical Assistance Services.	109	N418
WG0	The claim for these services was received after the time limit specified in the provider's agreement	29	
WG1	These services were disallowed by Utilization Management.	39	
WG2	Medical Records are required before outlier days will be reviewed for medical appropriateness.	252	M127
WG3	No approved authorization. Specialty Pharmacy Drug authorizations are handled through PBM Vendor. Please contact CVS/Caremark.	243	
WG4	No approved authorization. Specialty Pharmacy Drug authorizations are handled through PBM Vendor. Please contact CVS/Caremark.	243	
WG5	Benefits for this charge must be determined by filing through this member's appropriate pharmacy network.	109	N418
WG6	Claim denied due to no exception indicator or no notification on file.	252	N706
WGB	These services should be filed and paid by the behavioral health carrier at ComPsych Claims, PO Box 8379, Chicago, IL 60680-8379.	109	N418
WGC	The provider must submit the radiology report or office notes before benefits can be provided.	252	M31
WGD	Please refile this claim with the correct Explanation of Benefits from the other insurance carrier.	252	N4
WGE	Please submit a copy of the Medicare Explanation of Benefits so we can determine benefits.	252	MA04
WGF	Benefits cannot be provided until we receive previously requested information concerning this member's other insurance.	252	N686
WGG	The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	189	M81
WGH	The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	189	M81
WGI	This service is not normally covered for members in this age range.	6	N129
WGJ	Please submit an itemized bill for these dental services. Must include tooth number, surface, ADA code, number of X-rays, and service date.	252	N26
WH0	This claim was adjusted because it was previously processed under a different patient.	B13	
WH1	Exceeds maximum units considered medically appropriate.	119	N435
WH2	This service was included in the Bundled Episode Payment.	97	N525
WH3	The maximum amount payable under this member's coverage for this bundled episode.	45	
WH4	Benefits cannot be provided until the provider submits a brand name, manufacturer name, model and description.	252	M23
WH5	The information on this claim does not match the medical records submitted	B12	

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WH6	The provider must submit an itemized or detailed billing before benefits can be provided for this service.	16	N260
WH7	The provider must submit the NDC, drug name, Rx number, strength, day supply and quantity before benefits can be provided.	16	M123
WH8	Care Coordination fees are not payable.	96	N30
WH9	Care Coordination fees are not payable.	96	N30
WJ0	Please complete Accidental Injury report and return for review.	252	N493
WJ1	We need a claim that represents the entire stay. Please resubmit.	252	N26
WJ2	Benefits available for blood that is paid for and not replaced by donation. Resubmit with bill showing paid.	252	N26
WJ3	Resubmit with nurse's name, professional status, date of service, number of hours, charges, and statement from attending physician.	16	M60
WJ4	Please refile with itemized bill and Explanation of Benefits from the other insurance carrier.	16	N4
WJ5	The provider must submit name of injection and itemized bill before benefits can be provided.	252	N26
WJ6	The correct date of birth is needed before benefits can be determined for this service.	16	N329
WJ7	Benefits cannot be provided until we receive letter from member authorizing payment to be sent to the special recipient.	252	N685
WJ8	The provider must submit pre and post operative x-rays, report, and itemized bill before benefits can be provided.	16	MA121
WJ9	Submit an English version of all bills and supporting documentation before benefits can be provided.	16	N32
WK0	This lab service is required to be performed by Quest Diagnostics or Solstas Lab Partners.	185	
WK1	The provider must file this claim with his or her local BlueCross BlueShield plan for processing.	109	N418
WK2	Corrected Bill was received after the time limit for submission.	29	
WK3	Corrected Bill was received after the time limit for submission.	29	
WK4	The provider must submit a correct procedure code before benefits can be provided.	16	M51
WK5	Statement begin and end dates can't span calendar months TOB 89X and 66X.	273	N435
WK6	The provider must submit a correct occurrence code before benefits can be provided.	16	M46
WK7	The provider must submit a correct value code before benefits can be provided.	16	M49
WK8	The provider must submit a correct condition code before benefits can be provided.	16	M44
WK9	Revenue codes not keyed in date of service order.	16	M50

WHO This Home Health claim has a U804 bill type other than 0322, 0327, 0329, 0332, 0337, 0336, or 034x. 16 MA30 WI1 This Home Health claim has an invalid service date, from -thru dates or admission date. 16 MA31 WI2 The length of stay for this Home Health Claim is greater than 60 days. 16 MA31 WI3 The Home Health claim has more than one claim line with a HIPPS code and revenue code 0023. 16 M27 WI4 The Home Health claim has more than one claim line with a HIPPS code and revenue code 0023. 16 M20 WI4 The Home Health claim has more than one claim line with a HIPPS code and revenue code 0023. 16 M20 WI4 The Home Health claim has more than one claim line with a HIPPS code and revenue code 0027x or 0623. 16 M20 WI4 The Home Health claim has more than one claim line with a HIPPS code and revenue code 027x or 0623. 16 M20 WI4 This Home Health claim has a livest on the feethed be decaded that in the Bill during the episode of the Stage of the MA31 16 M30 WI4 This scalar must have at least on Nome Health skill related revenue code 16 M55 WI4 The growider must submat a cornect special scalar stage stage in the purpose of the sub			I	
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W13 The Home Health claim has more than one claim line with a HIPPS code and revenue code 0023. W14 The Home Health claim indicates non-routine supplies were provided during the episode, without revenue code 027x or 0623. W15 This Home Health claim is missing the Core Based Statistical Area in the UB-04 Value Amount with UB-04 Value Code 61. W16 This claim must have at least on Home Health visit related revenue code 16 M50 W17 A weight/rate record cannot be found for this particular facility ID, payer ID, effective date and Home Health Resource Group. 16 N471 W18 Therapy services billed with revenue codes 042x, 043x and 044x must be billed with the applicable modifier codes. W19 This service is not found on the fee schedule because it may be covered under the HHA episode rate, so it is not separately payable. 16 N471 WM0 The provider must submit a correct type of admission code before benefits can be provided. 17 National This charge exceeds the maximum allowable under this member's coverage. WM2 This is a subrogation adjustment. It will not affect previously assigned patient liability. WM3 The provider must submit a correct discharge status before benefits can be provided. 18 N50 WM4 The provider must submit a correct discharge status before benefits can be provided. 19 N50 WM4 The provider must submit a correct discharge status before benefits can be provided. 10 M43 WM4 Statement from/thru dates must correspond service line dates of service before benefits can be provided. 11 M43 WM5 Statement from/thru dates must correspond service line dates of service before benefits can be provided. 11 N657 WM7 Member has other insurance; please bill the primary carrier. Claim is paid due to the services being under the pay and chase option. 18 N522 WM7 Member has other insurance; please bill the primary carrier. Claim is paid due to the service on the claim. WM8 This modifier code or procedure code is not valid for the date of service on the claim. WM8 This son hold based on current premium in	WL1	This Home Health claim has an invalid service date, from -thru dates or admission date.	16	MA31
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WL6 This claim must have at least on Home Health visit related revenue code 16 M50 WL7 A weight/rate record cannot be found for this particular facility ID, payer ID, effective date and Home Health Resource Group. 16 NA71 WL8 Therapy services billed with revenue codes 042x, 043x and 044x must be billed with the applicable modifier codes. 182 N657 WL9 This service is not found on the fee schedule because it may be covered under the HHA episode rate, so it is not separately payable. 16 N471 WM0 The provider must submit a correct type of admission code before benefits can be provided. 45 WM1 This charge exceeds the maximum allowable under this member's coverage. 45 WM2 This is a subrogation adjustment. It will not affect previously assigned patient liability. 215 WM3 The provider must submit a correct discharge status before benefits can be provided. 16 N50 WM4 The provider must submit a correct admission status before benefits can be provided. 16 M43 WM4 The provider must submit a correct admission status before benefits can be provided. 16 M43 WM4 The provider must submit a correct admission status before benefits can be provided. 16 M43 WM5 Statement from/th	WL4	The Home Health claim indicates non-routine supplies were provided during the episode, without revenue code 027x or 0623.	16	M20
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WN1 The provider has agreed to accept the amount allowed under this member's contract for this service. 45	WMN	Payment of claim is pending registration as a TN Medicaid provider. Call 800-468-9736 for information on how to register.	16	MA112
	WMT	This claim is on hold based on current premium information. The member should contact his or her Human Resource office.	27	N30
WN2 The only appropriate bill types for SNF claims are 18X, 21X, 22X, and 23X. 16 MA30	WN1	The provider has agreed to accept the amount allowed under this member's contract for this service.	45	
	WN2	The only appropriate bill types for SNF claims are 18X, 21X, 22X, and 23X.	16	MA30

WW3 This claim contains service dates that are invalid or out of range. 16 M33 WW4 Only one Resource Utilitation Group can be billed per individual date of service. 16 N471 WM5 SNF Part B claims are not allowed to cross the calendar year boundary. 182 M52 WM6 Part B thraspy services billed with revenue codes 042x, 043x and 044x must be billed with the spitiable modifier codes. 182 N657 WW7 This service is non-covered because authorization guidelines were not followed for this service. 190 N10 WW8 The claim was adjusted following an external provider audit. 50 N10 WW9 The claim was adjusted following an external provider audit. 50 N10 WW9 The claim was adjusted following an external provider audit. 50 N10 WW9 Authorize is being discounted in accordance with HPNP agreement. The member is not responsible for this amount. 45				
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WQ8 Part B ambulance services must have the zip code of the location of pick-up present on the claim. 16 N53	WQ6	The HCT or HGB exceeds monitoring threshold without the appropriate modifier code.	4	N519
	WQ7	Part A SNF claims must contain at least one Resource Utilization Group Codes.	16	N471
WQ9 This revenue code is not covered for type of bill 22x. 16 M50	WQ8	Part B ambulance services must have the zip code of the location of pick-up present on the claim.	16	N53
	WQ9	This revenue code is not covered for type of bill 22x.	16	M50

WR0	This service is not covered when performed for the reported diagnosis.	11	N657
WR1	This procedure is redundant to the primary procedure and is limited by this member's plan.	234	M15
WR2	This service is not eligible since it was not filed according to the corrected billing guidelines. Please submit a corrected claim.	18	N522
WR3	Services performed in a school setting requires an Individualized Educational Plan.	252	M135
WR4	Medial Branch Block Injection Certification form invalid or incomplete	252	N473
WR5	The provider must file this claim to the non-emergency transportation broker for processing.	96	N61
WR6	The provider must submit a corrected EOB from the primary insurance before benefits can be provided.	16	N4
WR7	This claim was pended due to non-payment of premium and will be denied if the premium is not paid by the end of the grace period.	200	N619
WR8	The provider must submit a corrected EOB from the primary insurance before benefits can be provided.	16	N4
WR9	This is a subrogation adjustment. It will not affect previously assigned patient liability.	215	
WS0	This revenue code is not valid with the diagnosis on the claim. The provider should refer to billing guidelines.	96	N95
WS1	Submit dental claims to DentaQuest, 11100 W Liberty Drive, Milwaukee, WI 53224.	109	N418
WS2	This claim needs to be submitted to Magellan Rx	109	N418
WS3	This claim should be submitted to Department of Medical Assistance Services.	109	N418
WS4	Consumer Directed Services are not payable for the submitted claim. Please contact Public Partnerships, LLC, at 1-866-3009.	109	N418
WS5	These services will need to be billed to Vision Services Plan. Please contact the vendor at 1-800-877-7195.	109	N418
WS6	This service will need to be billed to the member's non emergent transportation provider.	109	N418
WS7	This claim should be submitted to Department of Medical Assistance Services.	109	N418
WS8	Medical review on these DRG outlier days has been completed. The outlier days have been denied.	69	
WS9	Medical records are required before outlier days will be reviewed for medical appropriateness.	252	M127
WSH	This is an excluded benefit under the member's coverage.	96	N30
WSP	This specialist does not participate in your network. Please contact your PCP for a new referral.	242	N130
WT0	Benefits for abortion, sterilization or hysterectomy services are excluded due to not meeting State or Federal requirements.	272	N584
WT1	Benefits for abortion, sterilization or hysterectomy services are excluded due to not meeting State or Federal requirements.	272	N584

WTZ Inits ancillarly service is not eligible for reimbursement when billed with a trage visit. 97 M86 WT3 senefits can not be provided since the dates of service must equal the number of units billed. The provider may file a corrected bill. 16 M53 WT4 the provider must submit a valid National Provider identifier before benefits can be provided. 208				
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WTA This is not a covered service since the primary carrier payment policies were not followed for this member. 276 N23 WTH Withhold Percentage Allowance	WT7	This service must be billed with a Category II code before benefits can be provided. The provider needs to file a corrected bill.	16	M51
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WUO Provider timely filing has been exceeded. 29 WU1 Provider timely filing has been exceeded. 29 WU2 Contracted funding agreement - Subscriber is employed by the provider of services. 139 WU3 Contracted funding agreement - Subscriber is employed by the provider of services. 139 WU4 Charges are eligible for Crossover or Do not match EOMB. 250 N479 WU6 The date of death precedes the date of service. 13 WU7 The date of death precedes the date of service. 13 WU8 Charges are eligible for processing via existing crossover arrangements. B11 WU9 Charges are eligible for processing via existing crossover arrangements. B11 WV0 This is a subrogation adjustment. It will not affect previously assigned patient liability. 215 WV1 Provider changed data from original claim related to COB. 169 WV2 Une item units cannot contain a decimal. 16 M53 WV3 The provider must submit a correct occurrence code before benefits can provided. 16 M46 WV4 This claim is considered a duplicate due to a previous settlement for Medicaid Provider. B13	WTA	This is not a covered service since the primary carrier payment policies were not followed for this member.	276	N23
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WV3 The provider must submit a correct occurrence code before benefits can provided. 16 M46 WV4 This claim is considered a duplicate due to a previous settlement for Medicaid Provider. B13	WV1	Provider changed data from original claim related to COB.	169	
WV4 This claim is considered a duplicate due to a previous settlement for Medicaid Provider. B13	WV2	Line item units cannot contain a decimal.	16	M53
	WV3	The provider must submit a correct occurrence code before benefits can provided.	16	M46
WV5 This claim was adjusted following a provider audit. 50 N10	WV4	This claim is considered a duplicate due to a previous settlement for Medicaid Provider.	B13	
	WV5	This claim was adjusted following a provider audit.	50	N10

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WV6	The provider must submit this patient's medical records. Please reference this claim number and member id when you submit the records.	252	M127
WV7	Surgical ICD Dates can't be more than three day prior to the Statement From Date or should not be greater than the Statement To Date.	16	N301
WV8	The provider must submit appropriate Attending Physician information before benefits can be provided.	206	N253
WV9	Medical Records need to be submitted to HDI in Las Vegas for reconsideration.	50	M127
WVA	The provider must file this claim with VA Health Administration Ctr. CHAMPVA, PO Box 65024 Denver, CO 80206-9024.	109	N36
WW0	Medical Records need to be submitted to HDI in Texas for reconsideration.	252	M127
WW1	This lab service is required to be performed by Quest Diagnostics.	242	N95
WW2	The servicing provider has billed this claim under the incorrect patient.	96	N10
WW3	These services are only covered when performed by the primary care provider or designee after the network discounts.	242	N450
WW4	The provider has agreed to accept the amount allowed under this member's contract for this service.	131	
WW5	Benefits for this service cannot be reimbursed until the correct provider indicator number is billed.	16	MA134
WW6	Provider must submit medical records to better support claim. Please reference claim number and member id when you submit the records.	252	M127
WW7	Provider must submit medical records to better support claim. Please reference claim number and member id when you submit the records.	252	M127
WW8	This claim contains one or more duplicate line items to the current claim. Please resubmit according to billing guidelines.	18	N111
WW9	This claim contains one or more duplicate line items to the current claim. Please resubmit according to billing guidelines.	18	N111
WX0	Member incarcerated medical necessity review required.	16	M60
WX1	Line item units cannot contain a decimal.	16	M53
WX2	Claim rejected due to member's Medicare eligibility status; unable to apply surcharge.	212	
WX3	The ICD code version submitted by the provider is not compliant with Federal Regulation for this service/discharge date.	16	M76
WX4	Benefits for this service cannot be reimbursed until the correct provider indicator number is billed.	16	MA134
WX5	This service is not paid in addition to or separately from the denied service.	234	N20
WX6	The provider has not contracted to provide this service.	45	
WX7	This charge exceeds the maximum allowable under this member's coverage.	45	
WX8	The provider must submit a valid pick up location zip code before benefits can be provided.	16	N53

WSD This claim was pended due to non-payment of premium and will be denied if the premium is not paid by the end of the grace period. 200 N539 WYO A corrected bill has been received. Any previous payment from this is being recouped. 50 N362 WY1 The units of service billed for the procedure code exceeds the allowed number of units. 50 N362 WY2 Benefits cannot be provided until a special review is completed. 181 M20 WY3 This edit occurred because a submitted procedure code is not valid for the service dates on the claim. 181 M20 WY3 This edit occurred because a submitted procedure code is not valid for the service dates on the claim. 181 M20 WY3 This gent occurred because a submitted procedure code is not valid for the service dates on the claim. 181 M20 WY3 This gent occurred because a submitted procedure code is not valid for the service occurred to cannot be provided until a special review or completed. 133 133 WY3 The potient is not liable for these charges. 87 8570 WY3 Provider is required to enroll in the Medicald Program where the member resides. 87 8750 WY3 Provider is required to enroll in the Medicald Program w				
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WZ5Medicare Advantage requires a completed CMS-2728-U3 form to be on file prior to adjudicating this claim.252M127WZ6Statement from/thru dates must correspond service line date of service before benefits can be provided.16MA31WZ7A maximum of one Patient Assessment Form is payable each calendar year under this member's coverage.119N362WZ8Delivery charges for mother and baby must be billed separately.16MA36WZ9This revenue code is not valid with the diagnosis on the claim. The provider should refer to billing guidelines.96N95WZABelow minimum units considered medically appropriate16N430WZBClaim is being reviewed to determine if a third party payer, subrogation has liability on this claim. Questionnaire to follow.252N686	WZ3	Exceeds maximum units considered medically appropriate.	119	N435
WZ6 Statement from/thru dates must correspond service line date of service before benefits can be provided. WZ7 A maximum of one Patient Assessment Form is payable each calendar year under this member's coverage. WZ8 Delivery charges for mother and baby must be billed separately. WZ9 This revenue code is not valid with the diagnosis on the claim. The provider should refer to billing guidelines. WZA Below minimum units considered medically appropriate WZB Claim is being reviewed to determine if a third party payer, subrogation has liability on this claim. Questionnaire to follow. 16 MA31 MA36 MA37 MA36 MA36 MA37 MA36 MA37 MA36 MA37 MA38 MA38 MA38 MA39	WZ4	Medicare Advantage requires a completed CMS-2728-U3 form to be on file prior to adjudicating this claim.	252	M127
WZ7A maximum of one Patient Assessment Form is payable each calendar year under this member's coverage.119N362WZ8Delivery charges for mother and baby must be billed separately.16MA36WZ9This revenue code is not valid with the diagnosis on the claim. The provider should refer to billing guidelines.96N95WZABelow minimum units considered medically appropriate16N430WZBClaim is being reviewed to determine if a third party payer, subrogation has liability on this claim. Questionnaire to follow.252N686	WZ5	Medicare Advantage requires a completed CMS-2728-U3 form to be on file prior to adjudicating this claim.	252	M127
WZ8 Delivery charges for mother and baby must be billed separately. WZ9 This revenue code is not valid with the diagnosis on the claim. The provider should refer to billing guidelines. WZA Below minimum units considered medically appropriate WZB Claim is being reviewed to determine if a third party payer, subrogation has liability on this claim. Questionnaire to follow. SAME OF THIS REPORT OF THE PROPRIES O	WZ6	Statement from/thru dates must correspond service line date of service before benefits can be provided.	16	MA31
WZ9 This revenue code is not valid with the diagnosis on the claim. The provider should refer to billing guidelines. WZA Below minimum units considered medically appropriate 16 N430 WZB Claim is being reviewed to determine if a third party payer, subrogation has liability on this claim. Questionnaire to follow. 252 N686	WZ7	A maximum of one Patient Assessment Form is payable each calendar year under this member's coverage.	119	N362
WZA Below minimum units considered medically appropriate 16 N430 WZB Claim is being reviewed to determine if a third party payer, subrogation has liability on this claim. Questionnaire to follow. 252 N686	WZ8	Delivery charges for mother and baby must be billed separately.	16	MA36
WZB Claim is being reviewed to determine if a third party payer, subrogation has liability on this claim. Questionnaire to follow. 252 N686	WZ9	This revenue code is not valid with the diagnosis on the claim. The provider should refer to billing guidelines.	96	N95
	WZA	Below minimum units considered medically appropriate	16	N430
WZC The Billing or Rendering National Provider Indicator (NPI) was not submitted. 206 N257	WZB	Claim is being reviewed to determine if a third party payer, subrogation has liability on this claim. Questionnaire to follow.	252	N686
	WZC	The Billing or Rendering National Provider Indicator (NPI) was not submitted.	206	N257

WZD	Improper or inappropriate use of the modifier billed with this procedure.	236	
WZE	Routine vision services should be filed to Eyemed for payment. We have forwarded your claim to EyeMed.	109	N418
WZF	CMHRS services are only billable through Magellan BH of VA. Re-submit to PO Box 1099; Maryland Heights, MO 63043.	109	N418
WZG	The member's Individualized Family Service Plan (IFSP) is not found or does not include this service.	284	M62
WZH	The member's Individualized Family Service Plan (IFSP) is not found or does not include this service.	284	M62
WZI	This service can only be billed with a professional modifier code and will not be reimbursed at the global or technical rate.	234	M15
WZJ	CMHRS services are only billable through Magellan BH of VA through 12/31/17. Re-submit to PO Box 1099; Maryland Heights, MO 63043	109	N418
WZL	This service was billed on the incorrect claim form type.	16	N34
WZM	This service was billed on the incorrect claim form type.	16	N34
WZN	Charges cannot be considered if the rendering provider's National Provider Identifier is not present on the claim.	16	N290
WZO	Frequency code 0 is handled as information only. Submit claim based on primary guidelines if member liability exists.	16	MA30
X01	The actual date of service is needed for this charge.	16	M52
X02	This charge should be filed at the time of delivery.	96	N56
X05	The provider must submit an itemized or detailed billing before benefits can be provided for this service.	252	N26
X06	The provider must submit the anesthesia time before benefits can be provided for this service.	16	N203
X07	The provider must submit the name and title of the individual who rendered this service before benefits can be provided.	16	N289
X08	The provider must submit a description of services rendered before benefits can be provided.	252	N350
X09	This principal diagnosis code is invalid. The provider must submit a valid code.	16	MA63
X10	DRG is not paid under the Acute Care Hospital Agreement.	45	
X11	The rate for this procedure was reduced based on the multiple surgery rule.	59	N644
X12	The provider has not contracted to provide this service.	185	N684
X13	This service is not paid in addition to or separately from the primary service.	234	N20
X14	This service is not covered for this member. The provider should submit the proper code or medical documentation.	16	MA39
X15	A valid DRG code could not be assigned for the coding that was submitted. The provider must submit valid codes.	236	N657

X16	The reimbursement for re-admission is included in the DRG allowance on a previous claim.	97	N525
X17	The provider must submit a correct procedure and revenue code combination before benefits can be provided.	199	N657
X18	This service is not normally performed for members in this age range.	6	N129
X19	Benefits have been reduced since the required authorization for this service was not obtained.	197	
X20	Benefits have been reduced since the required authorization for this service was not obtained.	197	
X21	These services were disallowed by Utilization Management.	39	
X22	Benefits for provider administered specialty drugs must be determined by filing through BCBST's pharmacy vendor.	109	N418
X23	Benefits for provider administered specialty drugs must be determined by filing through BCBST's pharmacy vendor.	109	N418
X29	This modifier is not compatible with this procedure code. The provider should submit the proper code.	4	N519
X30	Benefits cannot be determined until the provider submits the first date of dialysis.	16	MA122
X31	A split billing is needed for this confinement. The hospital must rebill according to the letter being sent to them.	96	N61
X32	The provider should refer to billing guidelines on filing days or units for Durable Medical Equipment claims.	108	N130
X33	The diagnosis code or procedure code is not valid for the date of service on the claim.	146	M76
X34	The provider must submit the x-ray report before benefits can be provided for this service.	252	M31
X35	The provider must file this claim with Magellan Health Services, PO Box 2154, Maryland Heights, MO 63043 (1-800-308-4934).	109	N418
X36	The provider must refer to the billing guidelines for proper billing of patient services.	96	N56
X37	Medical information is needed to complete a pre-existing review. Correspondence to the provider will follow.	252	N204
X38	Information has been requested from another provider to complete a pre-existing review. No action is required.	252	N204
X39	Pricing is based on a prior year agreement. The member is not liable for the amount that exceeds this pricing.	45	
X40	This amount represents your Medicare savings.	23	
X41	Submit English translation for each drug with an overseas claim form before benefits can be provided.	16	M123
X42	Submit an English version of Medical information before benefits can be provided.	16	N32
X43	Submit specific diagnosis code and overseas claim form before benefits can be provided.	16	MA63
X44	Submit clinical records and overseas claim form before benefits can be provided.	16	N163

X45	The provider needs to submit a statement of charges for each service with an overseas claim form before benefits can be provided.	16	MA31
X46	The provider needs to submit an itemized bill with an overseas claim form before benefits can be provided.	16	N34
X47	Provider needs to resubmit with charges itemized on a per day basis before benefits can be provided.	16	MA31
X48	The provider needs to submit itemized bill before benefits can be provided.	16	MA31
X49	Medical records have been requested for a provider audit reconsideration.	252	M127
X50	This amount was paid by your dental policy.	23	
X51	Vanderbilt employee PPO claims must be filed with Signature Health Alliance.	109	N418
X53	Benefits cannot be provided for services that have been determined not to be medically necessary.	50	N130
X54	This service is non-covered because authorization guidelines were not followed for this service.	197	
X55	The provider must file the claim with CareCentrix, PO Box 277947 Atlanta, GA 30384.	109	N418
X56	Medical records have been requested for a provider audit reconsideration.	252	M127
X57	The provider has agreed to accept the amount allowed under this member's contract for this service.	131	
X58	Medicaid Data Elements are Missing.	252	M127
X60	Benefits for services related to obesity, including surgical procedures, are not covered under this member's plan.	96	N30
X76	Medical records have been requested from the provider.	252	M127
X77	The provider must submit the NDC, drug name, RX number, strength, day supply and quantity before benefits can be provided.	16	M123
X78	The provider must refer to the billing guidelines for Home Infusion Therapy. A separate line must be billed for each date of service.	16	N61
X79	The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	189	M81
X80	This procedure requires an Origin and Destination modifier be billed. The provider should submit the proper code and modifier.	4	N519
X83	The provider must submit the proper code. No medication currently manufactured matching the code billed.	16	M119
X84	The date of birth follows the date of service.	14	
X85	The date of birth follows the date of service.	14	
X86	The provider must submit a correct procedure and revenue code combination before benefits can be provided.	199	N657
X87	The provider must submit a correct Type of Bill and revenue code combination before benefits can be provided.	16	MA30

X88The provider must submit a correct procedure and place of service combination before benefits can be provided.5X89The submitted procedure is disallowed because an add on code was billed without the presence of the related primary service/procedure.97X90This modifier code or procedure code is not valid for the date of service on the claim.4X91Each per diem must be filed with any medication/injection.16X92Date span is not within Home Health Agency benefit week.199X93Date span is not within Home Health Agency benefit week.96X94Each per diem must be filed with any medication/injection.50X95A copy of pathology reports for the patient is needed before the claim can be considered.252X96Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.252X97Benefits cannot be provided until we receive previously requested information concerning this member's other insurance.252X98The submitted procedure is disallowed because an add on code was billed without the presence of the related primary service/procedure.97XA1This member's maternity benefits include a twelve-month waiting period before benefits can be provided.179XA2Completed questionnaire is needed from the member before the claim can be processed.133XA3This dental service is not eligible for benefits under this member's coverage.96XA4This service is not eligible because it was not rendered by this member's PCP.185	M77 N122 N519 M123 N657 N56 M51 M30 MA04 N686
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XA3 This dental service is not eligible for benefits under this member's coverage. 96	
XA4 This service is not eligible because it was not rendered by this member's PCP.	N130
	N684
XA5 This procedure is considered investigative and is not covered under this member's plan. 55	N623
XA6 These charges will be considered if a referral is submitted.	N335
XA7 Routine examinations are not eligible for benefits under this member's plan. 49	N567
XA8 This member's coverage was not in effect on the date these services were provided. 27	N30
XA9 Charges for a pre-existing condition are not eligible for benefits. 51	N10
XAC Information concerning other insurance has been received and your records updated. This claim has been adjusted. 169	
XAD The accident date or onset date is needed from the provider before benefits can be provided for these services. 16	N305
XAQ The provider must submit the operative report or office notes before benefits can be provided. 252	1
XAR Provider must submit a corrected bill with modifier for the destination before benefits can be provided. 16	M29

XAT	Provider Audit Rec Call 423-755-5891		
XAX	Self-administered drugs not covered services under your plan.	96	N426
XAY	Self-administered drugs not covered services under your plan.	96	N426
XB0	This newborns date of birth and effective date are different, please contact the Department of Human Services.	26	N30
XB1	This member's plan does not cover a portion of the Medicare Part B deductible.	96	N30
XB2	Benefits for this service are excluded under this member's plan.	96	N30
XB3	Services for prenatal and postnatal care are not covered by this plan. Please re-file the labor and delivery charges only.	96	N188
XB4	We are deducting this amount because of an overpayment on a previous claim.	96	N10
XB5	Please submit a copy of the Medicare Explanation of Benefits so we can determine benefits.	252	MA04
XB6	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	252	MA04
XB7	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418
XB8	Your plan does not provide benefits for services by an out of network provider.	242	M115
XB9	Benefits cannot be provided for services not considered a medical emergency.	40	
XBA	These services should be filed and paid by the behavioral health carrier at ComPsych Claims, PO Box 8379, Chicago, IL 60680-8379.	109	N418
XBC	The provider must file this claim with Carelon Behavioral Health 1-888-474-0929.	109	N418
XBD	The provider must file this claim with OPTUM HEALTH SERVICES 1-855-437-3486 (1-855-Here4TN).	109	N418
XBE	Recoup due to Subrogation/Workers Comp Third Party Liability overpayment.	215	
XBF	The provider must submit a description of services rendered before benefits can be provided.	252	N350
XBG	The blood gases report is needed from the provider before benefits can be provided for these services.	252	N749
XBH	This is not a valid revenue code for this provider. The provider should refer to billing guidelines.	16	M50
XBI	Benefits are unavailable until we receive the information we requested in a recent letter to the provider's office.	252	M143
XBJ	The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	189	M81
XBL	This is a possible duplicate claim line of another claim line in history.	18	N111
XBM	The date of service is past timely filing guidelines.	29	

XBN	This edit occurred because a submitted procedure code is not valid for the service dates on the claim.	181	M20
XBO	The claim has been identified as an inpatient readmission, payment has been reduced.	249	
XBP	Units/Days were limited by a Utilization Management authorization.	198	
XBQ	Medicare denied this charge and the provider cannot bill you for it.	45	
XBR	Qualified Payment Amount for out-of-network services under the No Surprises Act. Provider will receive details in a separate mailing.	45	N860
XBS	This procedure does not normally require the services of an assistant surgeon.	54	N646
XBT	Services for prenatal and postnatal care are not covered by this plan. Please re-file the labor and delivery charges only.	96	N188
XBU	This is a deleted/invalid code or modifier for this date of service. The provider should submit the proper code.	182	N657
XBV	This service is not covered when performed in this setting.	96	N428
XBW	This service is not covered when performed for the reported diagnosis.	11	N657
XBX	The provider has not contracted to provide this service.	96	N448
XBY	The Hospital Related Dates are Missing/Invalid.	16	N173
XBZ	Incorrectly submitted to BCBST. For providers par with BlueHPN, file with par BlueHPN plan. All others, file to member's plan.	109	N418
XC1	Benefits for compound drugs purchased from a non-participating pharmacy are not covered under this member's plan.	96	N30
XC2	The provider must file this claim with the members home BlueCross BlueShield plan for processing.	109	N418
XC3	Please refile this claim with the correct Explanation of Benefits from the other insurance carrier.	16	N4
XC4	Your plan does not provide benefits for services by an out of network provider.	242	M115
XC5	This amount includes the benefits provided by this member's other insurance carrier.	23	
XC6	This claim contains dates of service prior to program effective date.	26	N128
XC7	Qualified Payment Amount for out-of-network services under the No Surprises Act. Provider will receive details in a separate mailing.	45	N860
XC8	The provider must submit a correct condition code before benefits can be provided.	16	M44
XC9	The TOB edit identifies claims that are missing or contains an invalid Type of Bill.	16	MA30
XCA	The claim has been identified as an inpatient readmission, payment has been reduced.	249	
ХСВ	Please refile this claim with the correct Explanation of Benefits from the other insurance carrier.	16	N4

		1	1
XCC	Benefits for services related to custodial care are not provided under this member's plan.	96	N30
XCD	Benefits cannot be provided until we receive previously requested information concerning this member's other insurance.	22	N197
XCE	Units/Days were limited by a Utilization Management authorization.	198	
XCF	Member must update their enrollment record with the Plan.	7	
XCG	Benefits cannot be applied because this drug is excluded from coverage.	96	N216
XCH	Please resubmit sperm/egg storage service with each year listed separately.	222	
XCI	Under FEHB law, payment is based on lesser of Medicare fee schedule or provider charge. Please submit performing provider NPI for Processing.	16	N277
XCJ	Under FEHB law, payment is based on lesser of Medicare fee schedule or provider charge. Submit TIN and address of provider for processing.	16	N209
XCK	Reimbursement amount applying is due to the service not meeting medical emergency guidelines.	45	
XCM	Benefits cannot be provided until the provider submits a Certificate of Medical Necessity.	252	N170
XCN	This is not a covered service since the primary carrier payment policies were not followed for this member.	276	
XCO	Benefits cannot be provided until we receive previously requested information concerning this member's other insurance.	252	N686
ХСР	Benefits for a compound prescription cannot be provided until the pharmacy supplies additional information.	16	M123
XCQ	This is not a covered service since the primary carrier payment policies were not followed for this member.	276	
XCR	Alacura providers must file claims directly to Alacura.	109	N418
XCS	This member group is not eligible for service received from this specific vendor.	204	
хст	The provider must submit the number of allergy tests performed and if they were scratch or intradermal tests.	16	N342
XCU	COU-Charges were reduced due to a coupon or discount applied at point of sale.	246	
XCV	The provider must submit the date of intraocular eye surgery or eye injury before benefits can be provided.	16	N305
XCW	Discharge date is within 48 hrs of the admission date on a previously paid inpatient claim. Readmission is not eligible for reimbursement.	97	M86
XCX	Miscellaneous code filed with an invalid number of units. Refer to Billing Guidelines.	16	M53
XCY	Benefits cannot be provided for this service because the required Electronic Visit Verification data was not received to the aggregator.	251	N705
XCZ	Benefits cannot be provided for this service because the required Electronic Visit Verification data was not received to the aggregator.	251	N705
XD1	This charge is a duplicate of a previously submitted charge for this member.	18	N702

XD7 We are deducting this amount because of an overpayment on a previous claim. 96 N10 XD3 The provider nutral file this claim with the member's coverage have been provided. 119 N640 XD5 Maximum benefits payable under this member's coverage have been provided. 119 N640 XD5 The maximum amount allowable for this equipment has been reached. 119 N640 XD6 We have paid the annual maximum allowable for this experience so these services for this member. 119 N640 XD7 This provider is not eligible under this member's coverage. 170 170 XD8 The tooth number is required to determine benefits. 16 N37 XD9 Provider has an agreement to file these services on a CMS1500 claim. 234 N20 XD0 This dental service is not eligible for benefits under this member's coverage. 96 N30 XDD This member is not eligible to receive pharmacy benefits since they have Medicare Part D. 96 N30 XDE The provider must file this claim with DentaQuest. 1212 N. Carporate Ploxy, Mequon, WI S3002 - 1-855-418-1623. 100 N418 XDF This expense is a duplicate of a previously submitted expense for this member. 18 N522 XDF This expense is a duplicate of a previously submitted with the Omnibus Budget Reconciliation Act of 1993, Please correct and re				
XD4Maximum benefits payable under this member's coverage have been provided.119N640XD5The maximum amount allowable for this equipment has been reached.119N640XD6We have paid the annual maximum allowable for these services for this member.119N640XD7This provider is not eligible under this member's coverage.170XD8The tooth number is required to determine benefits.16N37XD9Provider has an agreement to file these services on a CMS1500 claim.234N20XDCThis dental service is not eligible for benefits under this member's coverage.96N30XDDThis member is not eligible to receive pharmacy benefits since they have Medicare Part D.96N30XDDThe provider must file this claim with DentaQuest. 12121 N. Corporate Pkwy, Mequon, WI 53092 - 1-855-418-1673.109N418XDFThis expense is a duplicate of a previously submitted expense for this member.18N522XDHLifetime maximum or limit for Social Determinants of Health Pilot has been met or exceeded.35N117XDISenefits exceed 30 day annual maximum. Please send in Itemized charges per day for review.252N26XDLIncorrect info submitted to Medicare. Please resubmit correct information to Medicare.16M76XDLIncorrect info submitted to Medicare. Please sessibilit correct information to Medicare.16M76XDDNewborn charges have been denied under the subscriber's name. This newborn is not eligible for benefits.34XDDNewborn charges have been d	XD2	We are deducting this amount because of an overpayment on a previous claim.	96	N10
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	XDR	A copy of all diagnostic reports for the patient is needed before the claim can be considered.	252	N457
XDT Services performed during a Home Health Episode of Care are subject to consolidated billing. 234 N390	XDS	We cannot accept a claim that has been altered. Please resubmit with corrected receipt or bill from the provider of service.	16	N34
	XDT	Services performed during a Home Health Episode of Care are subject to consolidated billing.	234	N390

XDU	Duplicate of previous claim. If corrected billing, please resubmit according to billing guidelines.	18	N522
XDV	Therapy services must be billed with the applicable modifier codes.	16	N822
XDW	Clinical trials must be filed to Medicare for primary payment.	252	N479
XDX	There is no Crossover Coinsurance or Deductible. There is no patient responsibility due.	96	M41
XDY	There is no Crossover Coinsurance or Deductible. There is no patient responsibility due.	96	M41
XDZ	The provider must submit a valid National Drug Code, units and quantity qualifier before benefits can be provided.	16	M119
XE1	The charges for the 2004 dates of service were forwarded to another BlueCross BlueShield plan for processing.	B11	
XE2	The provider needs to submit itemized bill, claim form, and Explanation of Benefits or rejection from other insurance.	16	N4
XE3	We cannot accept claim that has been altered. Please resubmit with corrected claim, medical records, and provider signature.	16	MA70
XE4	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	109	N36
XE5	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	129	N48
XE6	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	109	N36
XE7	The provider needs to submit statement from physician explaining why more than one physician was necessary with an overseas claim form.	16	N34
XE8	Please submit this claim to the local BlueCross and BlueShield plan where services were rendered.	109	N802
XE9	Benefits cannot be provided until the provider submits a Certificate of Medical Necessity.	251	M42
XEA	The provider must file separate claims with itemized bills for each family member. Please resubmit.	16	N63
XEB	Benefits cannot be provided until we receive previously requested information from the member.	16	N34
XED	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	252	MA04
XEG	A copy of the EEG report with analysis is needed before the claim can be considered.	252	M31
XEP	This service must be approved by your EAP.	197	
XF0	This service is non-covered when billed by a practitioner with this specialty.	170	N95
XF1	The claim was adjusted due to Maternity Incentive requirements were not met.	50	N10
XF2	Multiple transitional care management codes have been filed within a specific time period.	96	M86
XF3	The required modifier is missing or the modifier is invalid for the procedure code.	16	N519

XF4	This procedure is considered a part of the global package previously paid on another claim.	97	N525
XF5	The units billed on this claim fall outside the range of units that are considered medically appropriate.	151	N362
XF6	The claim was adjusted to reflect your payment to the Division of TennCare.	131	
XF7	A charge in history relating to this procedure has been paid. Please re-file corrected bill with all necessary charges on one claim.	97	M15
XF8	The ambulance report is needed from the provider before benefits can be provided for these services.	252	N745
XF9	This claim was previously processed under another member's name and/or ID number in error.	96	N10
XFB	This service is not covered because benefits for the related condition are limited by a rider to this member's contract.	51	N607
XFD	This contract does not provide benefits for services intended to create a pregnancy.	96	N30
XFE	Benefits cannot be provided because this provider is designated as a sanctioned provider by the Federal Government.	185	
XFF	Benefits are not available for this service because the type of hospice care cannot be determined.	282	MA30
XFG	Benefits cannot be provided until a special review is completed.	252	N439
XFO	Service ordered by provider sanctioned by HHS. Federal law mandates no payment when insured by federally funded program.	185	
XFS	Provider sanctioned by HHS. Patient insured by federally funded healthcare plan. Federal law mandates no payment.	185	
XFT	This contract does not cover infertility treatment, services to create a pregnancy, or any resulting complications.	96	N30
XFW	This is a subrogation adjustment. It will not affect previously assigned patient liability.	215	
XG0	Maximum benefits payable under this member's coverage have been provided.	119	N587
XG1	Benefits for this service are excluded under this member's plan.	96	N30
XG2	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	252	MA04
XG3	This member's coverage was not in effect on the date this service was provided.	27	N619
XG4	This service is not covered because it is related to the member's employment.	96	N30
XG5	This service is not covered because it is related to the member's employment.	96	N30
XG6	This member's coverage was not in effect on the date this service was provided.	26	N30
XG7	This member's coverage was not in effect on the date this service was provided.	26	N30
XG8	This member's coverage was not in effect on the date this service was provided.	27	N619

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XG9	The maximum number of services payable under this member's coverage has been provided.	119	N362
XGA	Detailed description and either NDC, Drug Name, Quantity, Dosage, or original manufacturer or supplier invoice needed.	16	N350
XGB	Verify the name and date of birth of the patient.	16	MA36
XGC	Verify the number of services and date of services billed.	16	M53
XGD	Verify the procedure and modifier billed.	4	
XGE	Verify the relationship of the potential donor to the recipient.	16	MA60
XGF	Location of where the sleep study was completed is needed so that can be determined.	16	M77
XGG	Medical records to support the dental services being performed in an outpatient department are needed.	252	M127
XGH	Verify if all or part of the services are related to a hospital acquired condition or never event.	233	
XGI	A copy of the Medicare Part B explanation of benefits is needed so that benefits can be determined.	252	MA04
XGJ	Resubmit claim with correct type of bill for services provided. If inpatient, all room and board charges should be included.	16	MA30
XH0	An intermediary handles this service. The claim should be filed to the intermediary.	16	N8
XH1	Charges for outpatient services with this proximity to inpatient services are not covered.	60	N676
XH2	This is not a covered service unless the provider accepts assignment.	111	
XH3	This is not a covered service since appeal procedures were not followed or time limits were not met.	285	N584
XH4	This is not a covered service since the patient is enrolled in Hospice.	В9	
XH5	This is not a covered service since new patient qualifications were not met.	B16	
XH6	This is not a covered service since the diagnosis is inconsistent with the provider type.	12	N657
XH7	Information has been requested from the member.	95	
XH8	This is not a covered service since there was a lapse in coverage.	200	N650
XH9	This is not a covered service since prior hospitalization or thirty day transfer requirement was not met.	A6	
XHA	This claim has been paid up to the member's local plan's allowance.	45	
ХНВ	This is a Medicare Advantage Type claim. Medicare charge limitations may apply.		
XHC	The payment on this claim includes a Personal Savings Account or Health Reimbursement Account payment.	187	

XHD	The Payment Direction has been changed on this claim.		
XHE	This claim is being paid in full up to the charged amount.		
XHH	The maximum home health services under this member's coverage has been provided.	119	N362
XHI	The provider must submit this patient's progress notes or progress report before benefits can be provided for this service.	252	N393
ХНЈ	The provider must submit a photo or copy of this patient's X-rays before benefits can be provided for this service.	252	N40
XHK	The provider must submit the plan of treatment for this patient before benefits can be provided for this service.	50	M135
XHL	The provider must submit the psychiatric testing results before benefits can be provided for this service.	252	N467
XHM	This claim is a duplicate to a Medicare cross over claim which was processed directly by the member's plan.	18	N522
XHN	The provider must submit the tooth number before benefits can be provided for this service.	16	N37
XHO	Your plan does not provide benefits for services by an out of network provider.	242	M115
XHP	This claim was closed without processing by the Member's Plan.	227	
XHR	Your plan does not provide benefits for services by an out of network provider.	242	M115
XHS	This claim is a duplicate to a Medicare cross over claim which was processed directly by the member's plan.	18	N522
XHT	A copy of the PET/MRI/CT Scan reports for the patient is needed before the claim can be considered.	252	M31
XID	This contract does not cover infertility treatment, services to create a pregnancy, or any resulting complications.	96	N30
XIF	This contract does not provide benefits for services intended to create a pregnancy.	96	N30
XJ0	Claim needs to be filed to the Plan in whose service area the DME equipment was shipped to or purchased at a retail store.	96	N30
XJ1	Claim needs to be filed to the Plan in whose service area the referring provider is located.	109	N557
XJ2	Specialty Pharmacy Claim needs to be filed to the Plan in whose service area the ordering physician is located.	96	N30
XJ3	Claim needs to be filed to the Plan in whose service area the DME equipment was shipped to or purchased at a retail store.	96	N30
XJ4	Claim needs to be filed to the Plan in whose service area the referring provider is located.	109	N557
XJ5	Specialty Pharmacy Claim needs to be filed to the Plan in whose service area the ordering physician is located.	96	N30
XJT	Referring or Ordering provider's National Provider Identifier is required for Physical, Occupational, and Speech Therapy services.	16	N286
XJU	Ordering physician's National Provider Identifier is required for Durable Medical Equipment claims.	16	N264

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XJV	Medicare is excluded from the Pay and Chase Method. The provider must file to the member's Medicare plan for processing.	109	N418
XJW	Due to either federal or state mandate, attestation form is required in order to process claim.	252	N706
XJX	Due to either federal or state mandate, attestation form is required in order to process claim from a different servicing physician.	252	N706
XJY	Due to either federal or state mandate, attestation form was reviewed and did not meet requirements. This is provider discount.	96	N130
XK0	This is an inactive revenue code. The provider should refile with a valid code.	16	M50
XK1	The provider must submit a correct procedure and revenue code combination before benefits can be provided.	199	N657
XK2	Medicare considered this amount as a contractual write-off and the provider cannot bill you for it.	96	M41
XK3	This charge exceeds the maximum allowable under this member's coverage.	45	
XK4	The provider has agreed to accept the amount allowed under this member's contract for this service.	131	
XK5	The provider has not contracted to provide this service.	96	N448
XK6	This service is not paid in addition to or separately from the primary service.	234	N20
XK7	A maximum of one DME maintenance service is payable every 6 months.	119	N362
XK8	The provider has agreed to accept the amount allowed under this member's contract for this service.	131	
XK9	Claim contains DOS that span this patient's hospice benefit election date. Please reference applicable billing guidelines.	96	N143
XKA	This charge exceeds the maximum allowable under this member's coverage.	45	
XKB	Attending physician Medicaid ID not active for dates of service.	16	MA112
XKC	Operating physician Medicaid ID not active for dates of service.	16	MA112
XKD	Other physician Medicaid ID not active for dates of service.	16	MA112
XKE	Service/Facility Medicaid ID not active for dates of service.	16	MA112
XKF	Rendering physician Medicaid ID not active for dates of service.	16	MA112
XKG	Referring physician Medicaid ID not active for dates of service.	16	MA112
XKH	Purchased Service provider Medicaid ID not active for dates of service.	16	MA112
XKI	Ordering physician Medicaid ID not active for dates of service.	16	MA112
XKJ	This is a Third Party Liability Pay and Chase Partial Pay Adjustment.	215	

XKK	This is a Third Party Liability Pay and Chase Adjustment.	215	
XKM	The provider must submit this patient's medical records. Please reference this claim number and member id when you submit the records.	252	M127
XKN	Special review concluded that services were not eligible for reimbursement.	170	
XL1	The maximum annual benefits payable under this member's coverage have been provided.	119	N587
XL2	The maximum number of services payable under this member's coverage has either been met or exceeded on this claim.	119	N362
XL3	The maximum annual benefits payable under this member's coverage have been provided.	119	N587
XLT	The maximum lifetime benefits payable under this member's coverage have been provided.	119	N587
XM1	A new claim is being requested that meets Medicare payment guidelines. No action is required by the member.	96	N386
XM2	This member's coverage allows hearing aids for the subscriber and dependent children only.	96	N30
XM3	Services are eligible for processing under the Medicare crossover arrangement.	22	N479
XM4	This charge is more than Medicare allows for this service. The member is liable for this amount.	45	
XMA	These services are not covered for a dependent child under your plan.	96	N30
XMB	Please refile this claim with the correct Medicare Explanation of Benefits.	252	MA04
XMC	Medicare coinsurance is not covered by this policy.	96	N30
XMD	Please submit a copy of the Medicare Explanation of Benefits so we can determine benefits.	252	MA04
XMF	This provider is not eligible under this member's coverage.	170	
ХМН	This policy does not provide secondary benefits when Medicare is an HMO or Choice Plan.	96	N30
XMI	Benefits cannot be provided until the provider submits additional information to complete a pre-existing review.	252	N204
XMK	This date of service is prior to the effective date. The provider must file with the prior carrier.	26	N30
XMP	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
XMS	This member's coverage was not in effect at the time of this service.	27	N30
XMT	The timely filing limit as outlined in the member's contract/benefit has expired.	29	
XN1	The member failed to comply with the Mandatory Case Management requirement.	272	N584
XNC	The difference between the Medicare allowance and benefit maximum is not eligible under your contract.	122	

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XNE	This service is being reimbursed based on the non emergency fee schedule.	45	
XNF	Information is needed from the Member to complete a pre-existing review. Correspondence to the member will follow.	252	N204
XNM	Non maternity service not covered. Maternity Only Policy. For a list of eligible maternity codes see BCBST.com	96	N30
XNN	Benefits for this service are excluded under this member's plan.	96	N30
XNO	Your plan does not provide benefits for services by an out of network provider.	242	M115
XNP	This charge exceeds the maximum allowable under this member's contract for a non-participating provider.	45	
XNR	Benefits cannot be provided until we receive previously requested information concerning another party's liability.	20	
ХОВ	Your contract provides benefits for maternity services only at this facility.	242	N130
XON	Your plan does not provide benefits for services by an out of network provider.	242	M115
XOV	Please submit dates of service beginning 7/1/2015 to TRH/Farm Bureau Health Plans.	27	N30
XP1	This service is denied as a pre-existing condition because symptoms existed prior to this member's effective date.	51	N607
XP2	This service is denied as a pre-existing condition because treatment was recommended prior to this member's enrollment date.	51	N607
XP3	This service is denied as a pre-existing condition because treatment as received prior to this member's enrollment date.	51	N607
XP4	This service is denied as pre-existing because treatment was recommended prior to this member's effective date.	51	N607
XP5	This service is denied as pre-existing because treatment was received prior to this member's effective date.	51	N607
XP6	This member's coverage does not include benefits for congenital malformations that do not meet medical policy criteria.	96	N30
XP7	This service is not covered because benefits for the related condition are limited by a rider to this member's contract.	51	N607
XPA	This provider is not eligible under this member's coverage.	185	N684
ХРВ	This service is denied as a pre-existing condition because treatment prior to this member's enrollment date.	26	N30
XPC	This service is not eligible because it was not rendered by this member's PCP.	242	M115
XPD	This member's age is beyond the limiting age for these benefits.	96	N129
XPH	Physician services must be billed separately from the hospital claim.	89	N200
XPI	Benefits are not provided for personal convenience items.	96	N30
XPR	A non-participating provider has been used.	242	M115

XPW	Benefits for this service have a ninety-day waiting period.	179	
XPX	Your coverage has a one-year waiting period before benefits are available for this service.	179	
XQ1	The ER level 5 (99285) has been recoded to level 4 (99284) based on claim information with clinical validation and reimbursed accordingly.	16	N56
XQA	Non-covered charge(s). Coverage Policy has not been approved by BCBST Pharmacy and Therapeutics Committee.	133	
XQB	Non-covered charge(s). Coverage Policy has not been approved by BCBST Pharmacy and Therapeutics Committee.	133	
XQC	The National Drug Code submitted on this claim is invalid. The National Drug Code must contain eleven alpha-numeric characters.	16	M119
XQD	We are deducting this amount because of an overpayment on a previous previous claim.	96	N10
XQE	We are deducting this amount because of an overpayment on a previous previous claim.	96	N10
XQF	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	22	MA04
XQG	A detailed revenue code that identifies the specific service provided during the inpatient admission is required.	16	M50
XQH	Full aggregate amount allowed on previously processed claims. Patient is not liable for this charge.	234	M80
XQI	The provider has agreed to accept the approved aggregate amount allowed for this service.	131	
XQJ	This service is not covered when performed in this setting.	96	N428
XQK	The appropriate 340B modifier is required.	16	N822
XQL	Frequency code Alpha is handled as information only. Submit claim based on primary guidelines if member liability exists.	16	MA30
XQM	Some dates of service are not eligible for benefits. Submit claim including only the service dates the member is eligible for coverage.	239	
XQN	Benefits not provided for services and supplies with no charge or paid directly or indirectly by Local, State or Federal Government Agency.	96	M41
XQO	Provider to accept assignment of Medicare benefits. Patient not liable for difference between Medicare approved and actual charge.	96	M41
XQP	The level of the Evaluation and Management visit requires supporting documentation be submitted by the provider.	16	N56
XQQ	The units billed exceed the allowed amount for this procedure.	16	N430
XQR	This procedure was denied because the service is an incidental service that is not separately payable.	97	N390
XQS	The provider must submit a correct procedure and revenue code.	199	N657
XQT	The provider must submit an appropriately coded Evaluation and Management procedure.	16	N56
XQU	The National Drug Code submitted on this claim is invalid and/or not in effect for this date of service.	16	M119

XQV	Interim bill not acceptable for DRG pricing. Please submit all charges for this admission for benefit consideration.	16	M53
XQW	Payment is reduced because the diagnosis submitted on the claim is identified as a preventable emergency room diagnosis.	45	
XQX	The claim has been identified as an inpatient readmission, payment has been reduced by fifty percent.	45	
XQY	Discharge date is within 5 days of the admission date on a previously paid inpatient claim. Readmission is not eligible for reimbursement.	97	M86
XQZ	A detailed revenue code that identifies the specific service provided during the inpatient admission is required.	16	M50
XR0	Benefits cannot be provided since an authorization was not obtained for this service.	197	
XR1	This provider is ineligible to provide this pharmacy service.	185	N684
XR2	Diabetic Testing Supplies should be provided through Pharmacy.	109	N418
XR3	This medication is not covered under the member's medical plan. Please contact CVS Specialty at 1-888-265-7790 for pharmacy benefits.	185	N684
XRA	Payment is reduced because the diagnosis submitted on the claim is identified as a preventable emergency room diagnosis.	45	
XRB	Category III Codes allow zero payment if CMS does not establish a fee.	56	N623
XRD	Telehealth service filed without appropriate place of service or modifier.	5	M77
XRE	Please submit the name and National Provider Identifier of the rendering physician.	16	N277
XRF	The provider must submit this patient's medical records. Please fax to 1-888-535-5243 and reference the claim number and member ID.	252	M127
XRG	Category III Codes allow zero payment if CMS does not establish a fee.	56	N623
XRH	Telehealth service filed without appropriate place of service or modifier.	5	M77
XRI	Telehealth service filed without appropriate place of service or modifier.	5	M77
XRJ	Please resubmit claim with tooth number and/or surface for charge.	16	N37
XRK	The National Drug Code (NDC) does not match the procedure code filed on the claim.	16	M119
XRL	Need medical records showing record of a positive COVID-19 test.	252	M127
XRM	The claim is missing a gestational age diagnosis.	16	M64
XRN	The claim is missing a gestational age diagnosis.	16	M64
XRO	Medicare denied service due to inconsistent procedure, bill type, and place of service combination. Please confirm Medicare denial correct.	16	M77
XRP	Medicare's administrative process may not have been followed. Please confirm Medicare processes were followed and resubmit claim.	16	N480

XRQ	Patient's Medicare Beneficiary ID and Name received on the claim do not match. Please correct and resubmit.	16	MA92
XRS	Medicare denied pending corrected bill. Please resubmit your claim once Medicare has provided benefits.	16	N4
XRT	Pricing for this service was not found within fee schedules established for this provider.	96	N448
XRU	BlueCross BlueShield of Tennessee no longer administers claims for this group. Please contact employer for information.	27	N30
XRV	Please resubmit claim with a valid name and ID number for the other insurance carrier so that secondary payment can be determined.	251	MA04
XRW	The service billed must be filed to Medicare.	22	
XRX	This member's coverage does not provide benefits for prescribed drugs and other medications.	96	N30
XRY	Lifetime maximum or limit for Social Determinants of Health Pilot has been met or exceeded.	35	N117
XRZ	Provider has an agreement to file these services on a CMS1450 claim form.	234	N20
XS1	Secondary benefits will be paid until day one hundred of confinement. Benefits will then be based on medical necessity.	96	N30
XS2	The Bill type submitted on the claim is not compatible with the patient billed status.	16	MA43
XS3	These charges were included in the reimbursement for the mother's room and board.	128	
XS4	A new claim is being requested that meets Medicare payment guidelines. No action is required by the member.	96	N386
XS5	Oral/Self-administered medications are not covered.	96	N426
XS7	The provider has not contracted to provide this service.	96	N448
XS8	This procedure is considered investigative and is not covered under this member's plan.	55	N623
XS9	The required Supervising Physician is missing, invalid, or not on file with BlueCross BlueShield of Tennessee.	16	N297
XSA	This is money reimbursed due to another party's payment. Refer to Patient Owes column for any liability changes.	215	
XSB	This amount exceeds the member's liability per Health Care Financing Administration guidelines.	45	
XSD	We are providing secondary benefits to your prescription drug card.	23	
XSF	This coverage does not provide benefits for the treatment of self inflicted injuries.	96	N30
XSH	This amount was applied to the member's monthly patient pay.		
XSI	This coverage does not provide benefits for the treatment of self inflicted injuries.	96	N30
XSJ	The required Supervising Physician is missing, invalid, or not on file with BlueCross BlueShield of Tennessee.	16	N297

XSM For services after 1/1/2000, this claim is administered by United Behavioral Health 1-877-237-8574. XSN Non-skilled nursing home visits are not a covered benefit under this plan. B1 XSR Benefits have been reduced because a non-participating provider was used. 45 XSS Your supplemental BlueCross BlueShield coverage does not provide benefits for these charges. 96 XSV This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan. 97 XSW This service is not paid in addition to or separately from the primary service. 234 XSX Facility claim is required to determine if nursery charges are routine or non-routine. 252 XSY This charge is a duplicate of a previously submitted charge for this member. 18 XSZ This service is considered part of the primary procedure. Please do not bill separately. 97 XSm These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. 96 XT1 This member's contract does not provide benefits for contraceptives. 97	N30 N30 N30 M80 N20
XSR Benefits have been reduced because a non-participating provider was used. XSS Your supplemental BlueCross BlueShield coverage does not provide benefits for these charges. 96 XSV This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan. 97 XSW This service is not paid in addition to or separately from the primary service. 234 XSX Facility claim is required to determine if nursery charges are routine or non-routine. 252 XSY This charge is a duplicate of a previously submitted charge for this member. 18 XSZ This service is considered part of the primary procedure. Please do not bill separately. 97 XSm These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. 96 XT1 This member's contract does not provide benefits for contraceptives.	N30 M80
XSS Your supplemental BlueCross BlueShield coverage does not provide benefits for these charges. XSV This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan. YSW This service is not paid in addition to or separately from the primary service. XSX Facility claim is required to determine if nursery charges are routine or non-routine. XSY This charge is a duplicate of a previously submitted charge for this member. XSZ This service is considered part of the primary procedure. Please do not bill separately. XSM These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. YSO This member's contract does not provide benefits for contraceptives.	M80
This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan. Yhis service is not paid in addition to or separately from the primary service. Yhis service is not paid in addition to or separately from the primary service. Yhis facility claim is required to determine if nursery charges are routine or non-routine. Yhis charge is a duplicate of a previously submitted charge for this member. Yhis service is considered part of the primary procedure. Please do not bill separately. Yhese services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. Yhis member's contract does not provide benefits for contraceptives.	M80
XSW This service is not paid in addition to or separately from the primary service. XSX Facility claim is required to determine if nursery charges are routine or non-routine. 252 XSY This charge is a duplicate of a previously submitted charge for this member. 18 XSZ This service is considered part of the primary procedure. Please do not bill separately. 27 XSm These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. 28 XST This member's contract does not provide benefits for contraceptives. 29 XSM These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. 29 YST This member's contract does not provide benefits for contraceptives.	
XSX Facility claim is required to determine if nursery charges are routine or non-routine. XSY This charge is a duplicate of a previously submitted charge for this member. XSZ This service is considered part of the primary procedure. Please do not bill separately. XSM These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. YST This member's contract does not provide benefits for contraceptives.	N20
XSY This charge is a duplicate of a previously submitted charge for this member. XSZ This service is considered part of the primary procedure. Please do not bill separately. XSM These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. YT1 This member's contract does not provide benefits for contraceptives.	
XSZ This service is considered part of the primary procedure. Please do not bill separately. XSm These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. 96 XT1 This member's contract does not provide benefits for contraceptives. 98	N706
XSm These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. 96 XT1 This member's contract does not provide benefits for contraceptives. 96	N522
XT1 This member's contract does not provide benefits for contraceptives.	N19
	N30
	N30
XT2 This member's contract does not provide benefits for routine maternity services. 96	N30
XT3 This member's coverage does not provide benefits for Temporomandibular Joint Dysfunction - TMJ.	N30
XT4 Please submit modifier for services. 16	N822
XT5 Benefits are unavailable until we receive the information we requested in a recent letter to the ordering provider's office. 252	N706
XT6 The rendering provider is not eligible to perform the service billed. 185	N570
XT7 Payment is based on a 340B Ceiling Price. 45	
XT8 Please resubmit claim with tooth number and/or surface for charge. 16	N37
XT9 Your plan does not provide vision benefits for services by an out of network provider. 242	M115
XTA Services denied due to Office of Inspector General Exclusion. 299	
XTB We have provided extended benefits for a condition that was diagnosed and treated before this member's policy expired. 96	N30
XTC Prior approval is required for this drug. Call 1-800-572-1003 and choose the specialty pharmacy prompt. 96	1
XTD A completed certificate of medical necessity that has been signed and dated by the ordering physician is needed. 16	N54
XTE Rendering facility's name, address, facility type, National Provider Identifier, and Tax Identification Number is needed. 16	N54 M60

XTF	The timely filing limit as outlined in the member's contract/benefit has expired.	29	
XTG	Rendering provider's name, address, National Provider Identifier, and Tax Identification Number is needed.	16	N289
XTH	Services not eligible for Telehealth.	96	N776
XTI	This is a non-billable service for a provider that does not have the appropriate license/certification on file.	170	N95
XTJ	The provider must submit a description of services rendered before benefits can be provided.	252	N26
XTK	Medicare primacy changed during inpatient stay. The inpatient claim must be submitted to Medicare before we will consider payment.	252	N479
XTL	Each per diem must be filed with any medication/injection.	16	M123
		96	
XTM	The provider must refer to the billing guidelines for proper billing.		N56
XTN	Benefits cannot be provided since the dates of service must equal the number of units billed. The provider may file a corrected bill.	16	M53
XTP	This service has been reimbursed by a third party liability carrier.	20	
XTQ	Part A Skilled Nursing Facility claims must contain a valid Resource Utilization Group code.	16	N471
XTR	Benefits cannot be provided since the dates of service must equal the number of units billed. The provider may file a corrected bill.	16	M53
XTS	Date span is not within Home Health Agency benefit week.	199	N657
XTT	Date span is not within Home Health Agency benefit week.	96	N56
XTU	The appropriate 340B modifier is required.	16	N822
XTV	Benefit allowed for this equipment has been met and paid in full by Medicare and BlueCross BlueShield of Tennessee.	96	M41
XTW	Please submit Medicare Summary Notice or statement from Medicare indicating why Medicare denied services.	16	N480
XTX	Please submit explanation of benefits from other healthcare plan indicating why benefits were denied.	16	N480
XTY	Please verify type of bill and the present on admission (POA) indicator filed on claim and resubmit.	16	N434
XTZ	Benefits for this service are excluded under this member's plan.	96	N216
XU2	Benefits for this service are excluded under this member's plan.	96	N30
XU3	A copy of the Medicare Part B explanation of benefits is needed so that benefits can be determined.	252	MA04
XU4	A copy of the Medicare Part B explanation of benefits is needed so that benefits can be determined.	252	MA04
XUC	This charge exceeds the maximum allowable under this member's coverage.	45	

XUE	The accident date is needed before benefits can be determined for this service.	16	N305
XUF	Benefits available for interpretation of test results only if the test is covered. Claim for Sleep Study not on file and must be submitted.	B15	N674
XUN	This claim was for date of service July 1, 2015, or after, please submit to new Claims Administrator.	27	N30
XUQ	The service billed must be filed to Medicare.	22	
XUR	Part A Skilled Nursing Facility claims must contain a valid Resource Utilization Group code.	16	N471
XUS	This modifier code or procedure code is not valid for the date of service on the claim.	4	N519
XUT	Please sign this form and resubmit it to the address shown on this form.	251	MA75
XUU	Services do not usually require an anesthesiologist. If there were unusual circumstances, please submit additional information.	252	N706
XUV	Not a Medicare recognized provider type for benefit coverage for this service.	170	
XUW	Not a Medicare covered benefit.	96	N569
XUX	Need evidence of supervising physician or chiropractor.	16	N296
XUY	Benefits are not paid for services or supplies billed in advance. Please submit a claim after you receive the services or supplies.	110	
XUZ	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418
XV0	Services are not authorized for the level of care billed.	197	
XV1	Benefits for this service are limited to one time per twelve-month period.	119	M90
XV2	Benefits for this service are limited to one time per twenty-four month period.	119	N435
XV3	The onset of Illness or symptom cannot be the same as the date of service on the claim.	16	MA100
XV4	A correctly completed consent form is required from the provider before this service can be considered for benefits.	251	N28
XV5	A correctly completed consent form is required from the provider before this service can be considered for benefits.	251	N28
XV6	Medicaid claims must be submitted within three years from the date of service to be considered for payment.	29	
XV7	The billed diagnosis code was inappropriately coded based on ICD coding guidelines.	16	M64
XV8	The rendering provider is not eligible to perform the service billed.	185	N570
XV9	Service not payable when billed with a date span. Detailed billing is required to adjudicate this claim/service.	252	N26
XVA	Qualified Payment Amount for out-of-network services under the No Surprises Act. Provider will receive details in a separate mailing.	45	N860

XVB This service is considered part of a primary procedure. The member is not liable for this service under The No Surprise Act. XVC Qualified Payment Amount for out-of-network services under the No Surprises Act. Provider will receive details in a separate mailing. XVD No pricing found on the Medicaid fee schedule for the service billed. Therefore, this claim is applying zero payment.	97 45 96	N860 N860
XVD No pricing found on the Medicaid fee schedule for the service billed. Therefore, this claim is applying zero payment.	96	
		NAAO
		N448
XVE An invalid Claim Adjustment Reason Code was submitted on the primary explanation of benefits (EOB). A corrected EOB should be submitted.	252	N4
XVF The appropriate 340B modifier is required.	16	N822
XVG Federally Qualified Health Center and Rural Health Clinic services are not eligible for reimbursement on UB-04 claims.	96	N448
XVH This charge exceeds the maximum allowable under this member's coverage.	59	N644
XVI This is a bundled service. The payment is included in the service to which item/service is incident.	97	M80
XVJ Federally Qualified Health Center and Rural Health Clinic services are not eligible for reimbursement on UB-04 claims.	96	N448
XVK Medicare denied this charge and the provider cannot bill you for it.	45	
XVL The physician recertification date exceeds the allowable days.	16	N299
XVM Rendering NPI filed does not match the name of provider/facility listed.	16	N289
XVN Allowed amount adjusted due to Negotiation under federal law. No change to patient liability.	45	N860
XVO Allowed amount adjusted due to Independent Dispute Resolution under federal law. Patient liability unchanged.	45	N860
XVP Allowed amount adjusted due to Negotiation/Independent Dispute Resolution under federal law.	45	N860
XVQ The physician recertification date exceeds the allowable days.	16	N299
XVR These Medicare non-covered charges are considered for payment under the member's Medicaid benefit.	96	N30
XVS The vein study report is needed from the provider before benefits can be provided for these services.	252	N739
XVT Medicare paid this service in full.	23	
XVU The provider must submit a correct modifier and revenue code combination before benefits can be provided.	282	
XVV The provider must submit a correct modifier and revenue code combination before benefits can be provided.	282	
XVW The date of service filed on the claim is after the date of death.	13	
XVX The date of service filed on the claim is after the date of death.	13	
XVY Claim rejected pending review by provider. COVID-19 fee conflicts with provider's public website. Submit corrected bill or documentation.	252	N445

XXZ Service is not eligible for payment based on the provider's contractual agreement. 179 XXXII Benefits for this service have a six-month waiting period. 179 XXXII Benefits for this service have a six-month waiting period. 179 XXXII Benefits for this service have a six-month waiting period. 179 XXXII Benefits for this service have a sixty day waiting period. 252 M217 XXXII Medical records needed to make benefit determination. Please provide no later than 60 days from this notice. 18 M31 XXXII The provider must submit a procedure code before benefits can be provided. 252 M23 XXVII Medical records needed from facility for inpatient stay. 252 M127 XXVII Provider has opted out of Medicare. 179 179 XXXII Provider has opted out of Medicare. 199 M15 XXVII The procedure code billed has a rebundling activity with a procedure code billed on a previous paid claim for the same date of service. 97 M15 XXVII The provider must submit be provided in cessary for the procedure is missing or invalid. 96 N15 XXVII The provider must file this claim with CMS. The Medicare contractor to process this daim can be identified through the CMS website. 109 N10 XXVII Charges cannot be considered if the ren				1
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	XX4	The claim for these services was received after the time limit specified in the provider's agreement.	29	
XX6 Member is a Qualified Medicare Beneficiary and is not liable for the coinsurance amount. 2 N782	XX5	Member is a Qualified Medicare Beneficiary and is not liable for copay amount.	3	N783
	XX6	Member is a Qualified Medicare Beneficiary and is not liable for the coinsurance amount.	2	N782

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XX7	Provider's charges are covered under a capitation agreement with our plan.	24	
XX8	Reimbursement amount applying is due to medical emergency guidelines.	45	
XX9	Provider indicated that member did not receive this service. Benefits are not available for services not rendered.	96	N30
XXA	Benefits for credits, discounts, monetary allowances or other charges are not covered when member has no legal payment obligation.	96	M41
XXB	This dental claim has been forwarded to FEP BlueDental for processing of benefits.	B11	
XXC	The documentation received with this claim is not legible. Please resubmit using legible copies.	251	N205
XXD	Patient is enrolled in two Federal Employee Health Benefits Program health plans. Will need to verify enrollment before processing claim.	252	MA92
XXE	Payment for this service is included in the Global Fee allowance for the Blue Distinction Centers for Transplants.	97	
XXF	Provider type is Veterans Affairs, Department of Defense, or Indian Health Service. Member not liable for charges exceeding allowed amount	45	
XXG	Allergy injection billed with inappropriate diagnosis code.	11	N657
XXH	We have paid the annual maximum allowable for these services for this member.	119	N362
XXI	The maximum amount allowable for this equipment has been reached.	45	
XXJ	Per Federal Employees Health Benefit Law, member liability is limited to the lesser of the Medicare fee schedule or provider's charge.	45	
XXK	This service is not covered when performed on the same day as a related procedure.	273	N435
XXL	A history procedure code is within the global period of the procedure code on this line.	96	M86
XXM	This is a bundled service. The payment is included in the service to which item/service is incident.	97	M80
XXN	Submitted procedure is disallowed, mutually exclusive to other procedure.	96	N20
XXO	An add on procedure code has been submitted without the appropriate primary procedure.	B15	N122
XXP	Documentation or authorization is required to be submitted for review.	197	
XXQ	There are other procedures with prior dates of service that must be billed before this procedure.	59	
XXR	The claim has been paid using a price negotiated directly with the Blue Distinction Centers for Transplants.	131	
XXS	The rate for this procedure was reduced based on the multiple surgery rule.	59	N644
XXT	The provider has not contracted to provide this service.	96	N448
XY2	Procedure disallowed because split billing was detected. Services on the same day should be filed on a single claim.	A1	N149

XY3	This procedure is considered investigative and is not covered under this member's plan.	55	N623
XY4	The procedure is considered subset or redundant to the primary procedure and is limited by this member's plan.	97	M80
XY5	The maximum lifetime benefits payable under this member's coverage for this procedure have been provided.	119	N587
XY6	The provider has not contracted to provide this service.	96	N448
XY7	Benefits are not available for these services when the benefit criteria is not met.	96	N130
XY8	Your payment is being withheld in accordance with a regulatory notice. Refer to your letter of payment suspension for more information.	В7	
XY9	The provider must submit Room and Board charges correctly before benefits can be provided.	16	MA30
XYA	This code or service is considered non covered by DMAS.	96	N30
XYB	This claim should be submitted to Department of Medical Assistance.	109	N418
XYC	Multiple transitional care management codes have been filed within a specific time period.	96	M86
XYD	The required modifier is missing or the modifier is invalid for the procedure code.	16	N519
XYE	This procedure is considered a part of the global package previously paid on another claim.	97	N525
XYF	The units billed on this claim fall outside the range of units that are considered medically appropriate.	151	N362
XYG	A charge in history relating to this procedure has been paid. Please re-file corrected bill with all necessary charges on one claim.	97	M15
XYH	The provider must submit a correct procedure and revenue code combination before benefits can be provided.	199	N657
XYI	This add-on procedure is not eligible when the primary procedure is not eligible.	B15	N674
XYJ	This edit occurred because the procedure is identified as a component of another procedure also on the claim for the same service date.	97	M15
XYK	Benefits cannot be provided until a special review is completed.	133	
XYL	This service is not eligible since it was not filed according to the corrected billing guidelines. Please submit a corrected claim.	18	N522
XYM	Medicare Advantage requires a completed CMS-2728-U3 form to be on file prior to adjudicating this claim.	252	M127
XYN	Patient is a Medicaid/QMB. Review your records for any wrongfully collected deductible. This amount may be billed to a subsequent payer.	1	N781
XYO	Authorized budget for this service has been exceeded.	45	
XYP	This modifier code or procedure code is not valid for the date of service on the claim.	4	N519
XYQ	National Clinical Trial (NCT) identification number is required for patients participation in a clinical research study.	16	MA50

XYR	This edit occurred because only incidental services were reported.	97	N20
XYS	DMAS requires Physician Assistant services to be billed under the supervising physician. Consult DMAS regulations for more information.	185	N95
XYT	Provider's charges are covered under a capitation agreement with our plan.	24	
XYU	Provider's charges are covered under a capitation agreement with our plan.	24	
XYV	We received a Medicare claim for processing; however, because you do not have any liability for this service, we will not provide benefits.	96	M41
XYW	Benefits for provider administered specialty drugs must be billed by a BlueCare Tennessee participating specialty pharmacy provider.	109	N418
XYX	This service requires Electronic Visit Verification information to be billed on the 837P submission.	16	MA114
XZA	Paid according to the USA MCO/USA Senior Care Network contractual agreement.	1	N364
XZF	Hospice room and board charges must be billed by the Skilled Nursing facility.	16	MA30
XZG	Oral/Self-administered medications are not covered.	96	N426
XZH	Benefits for provider administered specialty drugs must be billed by a BlueCare Tennessee participating specialty pharmacy provider.	109	N418
XZI	The provider must submit a correct procedure and place of service combination before benefits can be provided.	5	M77
XZJ	Benefits for provider administered specialty drugs must be billed by a BlueCare Tennessee participating specialty pharmacy provider.	109	N418
XZK	These charges cannot be considered for payment since Medicare has denied the service as an exact duplicate of a previously paid claim.	276	
XZL	Benefits cannot be provided for this service because the required authorization or notification is not on file.	197	
XZM	The units of service billed for the procedure code exceeds the allowed number of units.	50	N362
XZN	These charges cannot be considered for payment until Medicare completes their review and makes a final benefit determination.	276	
XZO	These charges cannot be considered for payment until Medicare receives the information needed to completed their benefit determination.	276	
XZP	The required modifier is missing or the modifier is invalid for the procedure code.	16	N823
XZQ	Provide rationale as to why the sleep study was performed in a lab.	5	
XZR	Please submit the facility claim for the mother's maternity stay and resubmit the newborn claim.	B16	
XZS	Please provide a revenue code that specifies the level of infant care provided.	16	M50
YAB	This claim was adjusted because the service is eligible for benefits under the member's coverage.	169	
YAI	This claim was adjusted because additional information was received.	169	

YBC This claim was adjusted because the provider submitted a corrected billing. 169 YBE This claim was adjusted because we were notified that the provider billed for this service in error. 169 YBI This claim was adjusted to include the additional billing from the provider. 169 YCA Cost Share - Corrected - DO NOT ADJUST. 169 YCB Claim not handled as a corrected bill due to original claim was denied 169 YCC This claim was adjusted to correct the deductible, copay or coinsurance. 169 YCM This claim was adjusted to provide benefits secondary to Medicare. 23 YCO Share - Corrected - Additional Payment Made. 24 YCP This claim was adjusted because the member's BlueCross BlueShield coverage is primary. 169 YCS This claim was adjusted to provide benefits secondary to this member's other insurance coverage. 23 YDD This claim was adjusted because this service was processed on a previous claim. 169 YDP This service was previously denied as a duplicate in error. 169 YEU This claim was adjusted because the member's eligibility has been updated. 169 YGO This claim was adjusted to provide corrected benefits. 169 YHC Member has been enrolled in Contraceptive coverage. Please note new contraceptive Only identification number. YM1 </th <th></th>	
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YHC Member has been enrolled in Contraceptive coverage. Please note new contraceptive Only identification number.	
YM1 Your claim for this date of service is being adjusted due to an increase in Medicare's allowed amount. 169	
YM2 This claim was adjusted because this member's coverage has been terminated. 169	
YMP This claim was adjusted to provide corrected benefits. 169	
YMR This claim was adjusted because this member's coverage has been terminated. 169	
YNI This claim was adjusted to provide corrected benefits.	
YPD This claim was adjusted because this service is related to a pre-existing condition. 169	
YPP This claim was adjusted because it was determined that this service is not related to a pre-existing condition. 169	
YRB This claim was adjusted because the service is not eligible for benefits under the member's coverage. 169	
YRC This dental claim was adjusted because the service is not eligible for benefits under the member's coverage. 169	

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YRD	This claim was adjusted because this service is related to a condition limited by a rider to this member's contract.	169	
YSC	This claim was adjusted to provide corrected benefits under this member's coverage.	169	
YSD	This claim was adjusted because this service is not eligible for benefits under the member's coverage.	169	
YSP	This claim was adjusted because this service is eligible for benefits under this member's coverage.	169	
YTH	Although this member's benefit limit has been met, this claim has been reconsidered and adjusted pursuant to your separate mailing.	169	
YUM	This claim was adjusted because the authorization for this service has been updated.	169	
YWI	This claim was previously processed under another member's name or ID number in error.		
Z02	Agreement Discount Off Charges	45	
Z05	CoverKids - Claim to apply Network S rates.		
Z19	Call 1-800-276-1978 for claim detail if needed.		MR
Z21	Call 1-800-468-9736 for claim detail if needed.		MR
Z2B	This claim is being processed under your secondary coverage.	B11	N418
Z44	Call 1-800-468-9736 for claim detail if needed.		
Z55	Call 1-800-468-9736 for claim detail if needed.		MR
Z57	We are investigation to determine if this condition is pre-existing. If found to be pre-existing we may seek a refund.		
Z66	Call 1-800-468-9736 for claim detail if needed.		MR
ZA4	Call 1-800-468-9736 for claim detail if needed.		MR
ZA5	Call 1-800-468-9736 for claim detail if needed.		MR
ZA6	Call 1-800-468-9736 for claim if needed.		MR
ZA7	Call 1-800-276-1978 for claim detail if needed.		MR
ZA8	Call 1-800-468-9736 for claim detail if needed.		MR
ZAS	A reduction was applied to provider claim paid amount due to CMS Sequestration.		
ZB1	Call 1-800-705-0391 if you need assistance or claim detail.		
ZCB	IT IS TIME TO UPDATE INFORMATION REGARDING OTHER INSURANCE. PLEASE CALL 1-800-200-3704.	22	N197

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ZCD	IT IS TIME TO UPDATE INFORMATION REGARDING OTHER INSURANCE. PLEASE CALL 1-800-200-3704.	22	N197
ZCN	Non Par Pricing. This payment was recommended by MultiPlan. Questions: contact www.dataisight.com or 1-800-499-9708 and select option 6.	96	N30
ZCU	Please contact BCBST if a coupon was used to purchase your prescription.		
ZD1	These services were not approved by your EAP.		
ZD2	These services were approved by your EAP.		
ZD3	Benefits are being provided for this claim; however, future claims for this diagnosis should be submitted to your EAP.		
ZD5	Benefits were provided for this claim since a free cleaning coupon was redeemed. This service did not apply toward any annual maximum.		
ZDA	Your contract provides alternate courses of treatment that must meet accepted dental standards. Benefits are reduced.		
ZDK	This claim has been approved based on information provided by Duke EAP. Call 800-336-DUKE (3853) if you have any questions.		
ZDN	Call 1-800-924-7141 for claim detail if needed.		
ZE1	This member's claim has been separated for processing. No action is required.	B11	MA15
ZF5	Manual Recovery - Call 1-800-572-1003 for details		MR
ZHF	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
ZMB	You may not be liable for the amount indicated in the Amount You Owe Provider field. Please verify with your provider or primary carrier.	96	N30
ZMG	Call 1-800-924-7141 for claim detail if needed.		
ZMP	The Maintenance of Benefits provision in this member's contract may affect liability. Please see primary carrier's remittance for details.	96	N30
ZMR	Call 1-800-924-7141 for claim detail if needed.		
ZMS	This payment is secondary to benefits provided by Medicare. In network benefits have been applied.		
ZNN	In-Network benefits have been applied to this Out-of-Network Provider. You may be subject to balance billing.		
ZON	In-Network benefits have been applied to this Out-of-Network Provider. You may be subject to balance billing.		
Z00	In-Network benefits have been applied to this Out-of-Network Provider. You may be subject to balance billing.		
ZP1	Failure to obtain a prior authorization for this service will result in a \$250.00 copay.	96	N30
ZP2	Our records indicate that you have overpaid at the pharmacy for this date of service.		
ZP3	Benefits are not payable when Medicare's primary benefit exceeds this plan's maximum payment. The amount owed is shown as patient liability.	96	N30

ZPA	Provider Advance Recovery		
ZPS	Part D medications that are otherwise covered under the ESRD PPS bundled payment are not eligible for a separate Part D benefit payment	169	
ZPX	Charges not shown on the Explanation of Benefits are in pre-existing review. No action is required.	B11	MA15
ZR1	This claim was adjusted because additional information was received.	169	
ZS0	Call 1-800-558-6213 for claim detail if needed.		MR
ZS1	Call 1-800-558-6213 for claim detail if needed.		MR
ZS2	Call 1-800-558-6213 for claim detail if needed.		MR
ZS3	Call 1-800-558-6213 for claim detail if needed.		MR
ZS4	Call 1-800-558-6213 for claim detail if needed.		MR
ZS5	Call 1-800-558-6213 if claim detail is needed.		MR
ZS6	Call 1-800-558-6213 for claim detail if needed.		MR
ZS7	Call 1-800-558-6213 for claim detail if needed.		MR
ZS8	Call 1-800-558-6213 for claim detail if needed.		MR
ZS9	Call 1-800-558-6213 for claim detail if needed.		MR
ZSB	Call 1-800-924-7141 for claim detail if needed.		MR
ZSC	Call 1-800-468-9736 for claim detail if needed.		MR
ZSP	Call 1-800-924-7141 for claim detail if needed.		MR
ZST	Call 1-800-276-1978 for claim detail if needed.		MR
ZTB	The claim was adjusted to reflect your payment to the Bureau of TennCare.		
ZTC	Due to TennCare RAC Recovery your payment has been applied to the claim.		
ZTD	The claim was adjusted to reflect your payment to the Bureau of TennCare.		
ZTH	THCII - Review Episode of Care Report in BlueAccess.		
ZTM	Previous payment.		MR
ZY1	This procedure is not covered under the member's current benefit plan.	204	

Place of service on this claim is inconsistent based on a previously filed claim that indicates service performed in a different setting. Procedure code was denied because it is considered to be included in the monthly rental fee of another procedure code. Procedure code was denied because it is considered to be included in the monthly rental fee of another procedure code. Procedure code was denied because it is considered to be included under this member's plan. Procedure denied diagnosis code was inappropriately coded based on ICD coding guidelines. Procedure denied file is missing or the modifier is invalid for the procedure code. Procedure denied by Medicare and is not covered on this plan. The provider can bill the patient. Procedure was denied by Medicare and is not covered on this plan. The provider can bill the patient. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is past timely filing guidelines. Procedure code is not a billable service under this plan. Procedure code is not a billable service under this plan. Procedure code is not a billable service under with an invalid or inactive NPI number. Procedure denied because timely filing guidelines. Procedure denied due to multiple submissions for the technical or professional component of the same procedure. Procedure denied due to multiple submissions for the technical or professional component of the same				
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The billed diagnosis code was inappropriately coded based on ICD coding guidelines. 16 M64 27P The required modifier is missing or the modifier is invalid for the procedure code. 16 N833 27Q This charge was denied by Medicare and is not covered on this plan. The provider can bill the patient. 96 N30 27R This service is not covered when performed in this setting. 96 N428 27S This procedure code is not a billiable service under this plan. 27T The benefit for this service is included in the allowance for another service that has already been adjudicated. 27U The date of service is past timely filing guidelines. 27U The sprocedure was denied because it was billed by a provider with an invalid or inactive NPI number. 27D This procedure was denied because it was billed by a provider with an invalid or inactive NPI number. 27D This procedure was denied according to the portion of surgical care they provided during procedure(s). 27D Each provider is reimbursed according to the portion of surgical care they provided during procedure(s). 27D Procedure denied due to multiple submissions for the technical or professional component of the same procedure. 27D This CPT code has been denied because a more appropriate CPT code that better describes the services rendered should be billed. 27D This CPT code has been denied because a more appropriate CPT code that better describes the services rendered should be billed. 27D This complete is considered subset or redundant to the primary procedure and is limited by this member's plan. 27D M80 27D This service is not normally performed for members in this age range. 27D This service is not covered when performed on the same day as a related procedure. 27D This service is not covered when performed on the same day as a related procedure.	ZYM	This procedure code was denied because it is considered to be included in the monthly rental fee of another procedure code.	97	N19
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This charge is a duplicate of a previously submitted charge for this member. This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan. This principle diagnosis code is invalid. The provider must submit a valid code. This service is not normally performed for members in this age range. This service is considered part of the primary procedure. Please do not bill separately. This service is not covered when performed on the same day as a related procedure. This service is not covered when performed on the same day as a related procedure. This service is not covered because a submitted procedure code is not valid for the service dates on the claim.	ZYZ	Contracted amount for procedure is greater than submitted charge. Payment reduced to the submitted charge.	16	M54
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This service is not normally performed for members in this age range. This service is considered part of the primary procedure. Please do not bill separately. This service is not covered when performed on the same day as a related procedure. This edit occurred because a submitted procedure code is not valid for the service dates on the claim.	ZZ3	This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan.	97	M80
This service is considered part of the primary procedure. Please do not bill separately. 7 This service is not covered when performed on the same day as a related procedure. 7 This service is not covered when performed on the same day as a related procedure. 7 N19 7 N19 7 N19 7 N25 7 This edit occurred because a submitted procedure code is not valid for the service dates on the claim.	ZZ4	This principle diagnosis code is invalid. The provider must submit a valid code.	16	MA63
This service is not covered when performed on the same day as a related procedure. 273 N435 278 This edit occurred because a submitted procedure code is not valid for the service dates on the claim. 181 M20	ZZ5	This service is not normally performed for members in this age range.	6	N129
ZZ8 This edit occurred because a submitted procedure code is not valid for the service dates on the claim. 181 M20	ZZ6	This service is considered part of the primary procedure. Please do not bill separately.	97	N19
	ZZ7	This service is not covered when performed on the same day as a related procedure.	273	N435
ZZ9 A history procedure code is within the global period of the procedure code on this line. 96 M86	ZZ8	This edit occurred because a submitted procedure code is not valid for the service dates on the claim.	181	M20
	ZZ9	A history procedure code is within the global period of the procedure code on this line.	96	M86

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ZZH Submitted procedure is disallowed, mutually exclusive to other procedure. 96 N20 ZZI This service is a part of the original surgical procedure and is limited by this member's plan. 97 M144 ZZI A potential overpayment has been identified on this claim. 45 ZZI Only postoperative portion of global payment is allowed. 45 ZZM The single/unilateral code disallowed - billed more than once on a single date of service. Replaced with Bilateral code. 59 N644 ZZN Non-physician assistant at surgery services are included in the physician/facility payment. 54 N666 ZZO The submitted procedure is disallowed because it does not typically require a co-surgeon according to CMS Medicare guidelines. 54 N664 ZZP The submitted procedure is disallowed because it does not typically require a team of surgeons according to CMS Medicare guidelines. 54 N666 ZZQ Procedure qualifies for multiple endoscopy reduction and payment should be reduced. RVU value for this line should be reduced. 97 M15 ZZU Multiple procedures billed for the same service date in which a reduction is applicable, per CMS guidelines. 45 ZZV The procedure code describes a physician interpretation for service and is not appropriate in place of service. 96 M97	ZZF	This is a bundled service. The payment is included in the service to which item or service is incident.	234	M15
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2ZQ Procedure qualifies for multiple endoscopy reduction and payment should be reduced. RVU value for this line should be reduced. 2ZU Multiple procedures billed for the same service date in which a reduction is applicable, per CMS guidelines. 2ZV The procedure code describes a physician interpretation for service and is not appropriate in place of service. 2ZW This claim line is being disallowed because and E and M code is within the global period with a same diagnosis category by same provider. 2ZX This service is not paid in addition to or separately from the primary service. 2ZY This health service code was denied as it is not a covered service when billed with the submitted diagnosis code. 2ZY The patient's age or gender conflicts with the procedure and/or diagnosis code. 234 M67 255 P03 A diagnosis code which meets medical necessity for this procedure code is missing or invalid 256 M76 257 Documentation or authorization is required to be submitted and/or reviewed.	ZZO	The submitted procedure is disallowed because it does not typically require a co-surgeon according to CMS Medicare guidelines.	54	N646
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p03 A diagnosis code which meets medical necessity for this procedure code is missing or invalid p04 Documentation or authorization is required to be submitted and/or reviewed. 16 M76	p01	A required procedure code or modifier is missing or invalid on the current line or an associated claim line	16	M67
p04 Documentation or authorization is required to be submitted and/or reviewed.	p02	The patient's age or gender conflicts with the procedure and/or diagnosis code.	16	M51
	p03	A diagnosis code which meets medical necessity for this procedure code is missing or invalid	16	M76
p05 This is a possible duplicate claim line of another claim line in history 18 N111	p04	Documentation or authorization is required to be submitted and/or reviewed.	197	
	p05	This is a possible duplicate claim line of another claim line in history	18	N111

p06	This E/M procedure code is inappropriately reported for an established or new patient.	16	N657
p07	The units have exceeded the allowable maximum frequency per time span	119	N640
p08	The required modifier is missing or the modifier is invalid for the procedure code	16	N823
p09	This is a non-covered, restricted, reporting only or bundled procedure code or service	96	N130
p10	The place of service code is missing or invalid for the procedure code	16	M77
p11	The provider specialty is missing or invalid for the place of service or procedure code	8	
p12	A procedure reduction should be applied to this claim line based on the procedure code or modifier submitted	59	
p13	The type of bill, procedure code, or revenue code are conflicting	16	N657
p14	The procedure code has an unbundle relationship with another procedure on this claim or on a claim in history	97	M15
p15	This claim or claim line is missing information which is needed for editing	16	M84
p16	There is a conflict with the occurrence, value or condition code and the procedure, revenue code or TOB on the claim	16	N657
p17	A potential overpayment has been identified on this claim	97	
p18	This claim has been filed out of sequence.	16	N182
p22	The token charge on this claim is less than \$1.01 billed by provider.	16	M54
s01	The patient status is not valid.	16	MA43
s02	The patient status code is missing.	16	MA43
s03	Procedure code is limited coverage code.	16	N657
s04	Procedure code is limited coverage since there is an associated limited diagnosis code on the claim.	16	N657
s05	Procedure codes 02RK0JZ and 02RL0JZ are limited coverage when Z006 diagnosis code is present.	16	N657
s06	The Other diagnosis code indicates that a wrong procedure was performed.	11	MA63
s07	The Principal diagnosis code indicates that a wrong procedure was performed.	11	MA63
s08	Procedure code 9672 should not be reported when the patient's length of stay is less than four days	16	N657
s09	Non-exempt facility submitted admission diagnosis with Hospital Acquired Condition	233	
s10	Non-exempt facility submitted principle diagnosis code with Hospital Acquired Condition	233	

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s11	Non-exempt facility submitted Non-exempt diagnosis w/POA of 1 or X	16	N434
s12	The Principal Diagnosis code requires a non-exempt POA indicator of 1 or X	16	N434
s13	The Other diagnosis code requires a non-exempt POA indicator of 1 or X	16	N434
s14	Non-exempt facility submitted other diagnosis code with Hospital Acquired Condition	233	
t02	The required procedure code is missing according to a Local Coverage Determination.	16	M51
t03	The provider specialty does not meet criteria for the procedure code according to a Local Coverage Determination.	8	MA130
t04	Add-on procedure code billed with primary procedure on Claim-Id Line.	16	MA66
t05	History Procedure Code has incidental relationship with this procedure code.	97	M80
t07	The diagnosis on the line is inconsistent with the procedure according to a Local Coverage Determination.	11	N657
t08	This edit occurred because the procedure has a profile relationship according to the Local or National Coverage Determination.	96	N386
t09	This procedure requires documentation according to a Local Coverage Determination.	252	M127
t10	This add-on procedure is not eligible when the primary procedure is not eligible.	B15	N674
t11	Bilateral Procedure reduction.	59	N670
t12	Procedure code and history procedure code indicate multiple imaging services. A 25% reduction of the technical component applies.	59	
t13	Procedure code and history procedure code indicate multiple imaging. 25% reduction of the technical component applies.	59	
t14	This procedure is missing an appropriate modifier when related to an evaluation and management visit in patient history.	16	N823
t15	This procedure is missing an appropriate modifier when billed with an evaluation and management code.	16	N823
t18	The maximum frequency for this procedure code has been exceeded.	119	N362
t19	A multiple procedure reduction of 50 percent of the allowed amount should be applied to this claim line.	59	N670
t20	An operative report must be reviewed when more than 5 procedures have been performed on the same date of service.	252	M29
t21	A multiple procedure reduction of 50% of the allowed amount should be applied to History Claim.	59	
t22	An add on procedure code has been submitted without the appropriate primary procedure.	B15	N122
t23	Procedure code is a non-covered service per the Non-covered Service list.	96	N30
t24	Add-on procedure code has been submitted without an appropriate primacy procedure code.	B15	N122

t25	Procedure Code has an incidental relationship with another procedure code.	97	M80
t26	Only intraoperative portion of global payment is allowed.	59	
t27	Only postoperative portion of global payment is allowed.	59	
t28	Only preoperative portion of global payment is allowed.	59	
t29	Only intraoperative portion of global payment is allowed.	59	
t30	Per Medically Unlikely Edits, the units of service billed for this procedure code exceeds the allowed units.	96	N362
t31	The presence of an anesthesia modifier indicates a reduction in payment.	59	
t32	Anesthesia code on this line requires an appropriate modifier.	4	N519
t33	This edit occurred because a professional component modifier is needed for this place of service for this diagnostic procedure code.	4	N519
t34	The procedure code describes the physician service. Use of modifier ZY is not appropriate.	4	N519
t35	This procedure code describes only the technical portion of a service or diagnostic test. Modifier ZY is not appropriate.	4	N519
t36	The procedure code describes the global code of a service or diagnostic test. Modifier ZY is not appropriate.	4	N519
t37	The procedure code describes a physician interpretation for service and is not appropriate in place of service.	96	M97
t38	The procedure code is a service covered incident to a physician's service and modifier XY is not appropriate.	4	N519
t39	The procedure code is a service covered incident to a physician's service and modifier YZ is not appropriate.	4	N519
t40	The use of a modifier is not typical for the billed procedure.	4	N519
t41	This procedure was performed on the same day of a history procedure by the same provider. The diagnosis indicates same condition.	96	M86
t42	Items that do not have a physician order or prescription are not covered.	173	N667
t43	The ESRD Supply HCPCS code billed is not Payable to DME Suppliers.	96	N95
t44	The maximum frequency for the DME procedure code has been exceeded	96	N435
t45	The procedure was performed on the same day of a history procedure by the same provider. The diagnosis indicates condition	96	M86
t46	A diagnosis code or codes which meets medical necessity for the procedure code is missing or invalid.	146	M76
t47	A history procedure code by the same provider is in the global period of the procedure code for the same condition	96	M86
t48	A diagnosis code, which meets medical necessity for the procedure code is missing or invalid.	146	M76

t49	All claim lines on the same claim must contain the modifier EY.	4	N519
t50	Modifier GK cannot be submitted alone, another line with GA or GZ must be present on the same claim.	4	N519
t51	Item or service statutorily excluded or does not meet the definition of any Medicare benefit.	4	N519
t52	The procedure code is a non covered code or the modifier is a non covered modifier.	16	N657
t53	These are non-covered services because this is not deemed a medical necessity by the payer.	50	
t54	A diagnosis code, which meets medical necessity for the procedure code is missing or invalid.	146	M76
t55	In the absence of injury or direct exposure, preventive immunization and its administration is not covered.	50	N130
t56	A history procedure code is within the global period of the procedure code on this line	96	M86
t57	The date of service is past timely filing guidelines.	29	
t58	The units of service billed for the procedure code exceed the allowed number of units.	50	N362
t59	Per NCCI edits, the a history procedure has an unbundle relationship with the procedure code	97	M80
t60	Per NCCI edits, the procedure code has an unbundle relationship with a code in history	97	M80
t63	The procedure code has an unbundle relationship with a history procedure code.	97	M80
t64	A history procedure code has an unbundle relationship with the code on the current line	97	M80
t65	The frequency of the procedure code has exceeded the allowable maximum frequency for this code	119	N435
t66	Procedure is identified as an ambulance code and requires an ambulance modifier	4	
t67	The presence of modifier GZ indicates this is not eligible for payment.	96	N30
t68	Procedure indicate multiple imaging services were performed. Per CMS, a 25% reduction of the professional component applies.	59	
t69	Procedure indicate that multiple imaging services were performed. Per CMS, a 25% reduction of the professional component applies to history.	59	
t70	A multiple procedure reduction should be applied to this claim line	59	
t71	Based on this claim line, a multiple procedure reduction should be applied to history	59	
u87	The unit threshold for this procedure has been exceeded.	151	N362
u88	The maximum allowable of units has been exceeded.	151	N362
u89	This procedure is not allowed for reimbursement.	16	N56

u90	This procedure is not appropriate for this patient's gender.	7	
u91	There were multiple procedures that were billed during this time period that exceed the maximum allowed.	119	N362
u92	This medical condition does not justify the procedure performed.	11	N657
u93	This service is not allowed in addition to the other service billed on the same date.	231	
u94	This procedure is not covered when performed in this place of service.	58	
u95	There were multiple procedures that were billed on the same day that exceed the allowed time period.	119	N362
u96	There was not sufficient time between these procedures so this service is not allowed.	119	N362
u97	This procedure is only allowed once per lifetime for this plan.	119	N362
u98	This procedure is not appropriate for the patient's age.	6	N129
u99	This claim requires configuration review.	133	
w01	Invalid diagnosis code unnecessary 4th/5th digit for patient's admission on/discharge date.	146	M76
w02	Invalid diagnosis code missing 4th/5th digit for patient's admission/ discharge date.	146	M76
w03	Invalid procedure code. Not found on table of valid ICD-CM codes.	16	M51
w04	Invalid Procedure code. Unnecessary 4th digit.	16	M51
w05	Invalid Procedure code. Missing 4th digit.	16	M51
w06	Invalid Procedure code. Found on ICD-CM table but not valid for patient's admission/discharge date.	16	M51
w07	Invalid Procedure code. Unnecessary 4th digit for patient's admission/ discharge date.	16	M51
w08	Invalid Procedure code. Missing 4th digit for patient's admission/ discharge date.	16	M51
w09	This claim lacks required HCPCS Level II code for radiopharmaceutical drug.	16	M20
w15	Only whole blood revenue codes can be used when billing for whole blood.	16	M50
w16	This HCPCS code is not approved for a partial hospitalization claim.	16	M51
w17	This HCPCS code can only be billed on a partial hospitalization claim.	16	M51
w18	The charge on this line exceeds the token charge \$1.01.	16	M54
w19	This service was provided after the end date of coverage for the National Coverage Determination Policy.	96	N386

w20	This service is denied per Medically Unlikely Edits, the units billed exceed the allowable units for this code.	96	N362
w21	Per LCD or NCD, the patient's age does not meet policy requirements for the procedure code and/or diagnosis code.	6	N115
w22	Per LCD or NCD guidelines, at CTP/HCPCS code is needed to meet policy requirements.	96	N115
w23	Per LCD or NCD guidelines, procedure code has a denied relationship.	96	N115
w24	Per LCD or NCD, the frequency does not meet policy requirements for the procedure code.	96	N115
w25	Per LCD or NCD, the patient's gender does not meet policy requirements for the procedure code and/or a diagnosis code.	7	N115
w26	Per LCD or NCD guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.	96	N115
w27	Per LCD or NCD guidelines, a modifier, which meets medical necessity for the procedure code is missing or invalid.	96	N115
w28	Per LCD or NCD, the condition code is missing or does not meet policy requirements for the procedure code.	96	N115
w29	Per LCD or NCD guidelines, a primary diagnosis code, which meets medical necessity for the procedure code is missing or invalid.	96	N115
w30	Per LCD or NCD guidelines, procedure code has a profiled relationship. Please review the policy.	96	N115
w31	Per LCD or NCD guidelines, documentation should be requested or reviewed for the procedure code	96	N115
w32	Per LCD or NCD guidelines, a secondary diagnosis code, to meet medical necessity for the procedure code, is missing or invalid.	96	N115
w33	Per LCD or NCD guidelines, a tertiary diagnosis code, to meet medical necessity for the procedure code is missing or invalid.	96	N115
w34	Per LCD or NCD, the revenue code does not meet policy requirements for the procedure code.	96	N115
w35	Per LCD or NCD, the type of bill does not meet policy requirements for the procedure code.	96	N115
w36	Per LDC or NCD, the value code is missing or does not meet policy requirements for the procedure code.	96	N115
w37	Per Medically Unlikely Edits, the units of service billed for the procedure code exceed the allowed units	50	N362
w38	Per NCCI edits, a history procedure has an unbundle relationship with the procedure code on this line	97	M80
w39	Per NCCI edits, the procedure code has an unbundle relationship with one in history	97	M80
w40	The Statement Covers Period Through Date of Service is past the facility timely filing limit.	29	
w41	An ICD-9 Diagnosis code in history was compared to an ICD-10 diagnosis code on the current claim.	96	N569
w42	The HCPCS add-on code is lacking a required primary code on the claim.	234	N122
w43	Procedure code must be submitted with required device or procedure code on the same date of service.	16	M20

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w44	Review the conditional or independent bilateral procedure code for possible payment adjustment	59	N644
w45	Procedure code is retained from the transfer relationship	P14	
w46	History procedure code is retained from the transfer relationship	P14	
w47	The units have exceeded the allowable maximum frequency per time span	119	N640
w48	The units including history have exceeded the allowable maximum frequency per time span.	119	N640
w49	The units have exceeded the allowable maximum frequency per time span	119	N640
w50	The units have exceeded the allowable maximum frequency per time span	119	N640
w51	Multiple procedures billed for the same Service Date in which a reduction is applicable, per CMS guidelines.	59	N644
w52	Procedure Code should be denied due to a rebundle into another code.	97	M80
w53	History procedure should be denied due to a rebundle into another code.	97	M80
w54	The surgical procedure code contains a termination modifier, and all other services on this claim should be denied based on CMS guidelines.	97	M80
w55	The surgical procedure code contain a terminated modifier and should be reviewed for a 50% reduction.	59	
w56	Bundled codes transfer into new procedure to be added to this claim.	59	
w57	Age and gender conflict; the Admission diagnosis code is not permissible for the patient's age and gender	16	MA65
w58	Age and gender conflict; the Other diagnosis code is not permissible for the patient's age and gender.	16	M64
w59	Age and gender conflict; the Principal diagnosis code is not permissible for the patient's age and gender.	16	MA63
w60	The Admission diagnosis code is invalid because it has an incomplete number of digits.	16	MA65
w61	The Admission diagnosis code is invalid	16	MA65
w62	The Admission diagnosis code is missing	16	MA65
w63	The Other procedure code is invalid based on the Admission date	16	M67
w64	The Other diagnosis code is invalid because it has an incomplete number of digits.	16	M64
w65	The Other procedure code must contain a fourth or fifth digit in order to be valid.	16	M64
w66	The Other diagnosis code must be valid and is effective based on the through date on the claim.	16	M64
w67	The Other procedure code must be in the ICD-PSC code Table.	16	M67

w68	The Other procedure code contains an unnecessary digit.	16	M67
w69	The Principal procedure code must be valid and is effective based on the admission date on the claim.	16	MA66
w70	The Principal diagnosis code does not contain a complete number of digits.	16	MA63
w71	The Principal procedure code must be complete in order to be valid.	16	MA66
w72	The Principal diagnosis code is not valid based on the through date on the claim.	16	MA63
w73	The Principal procedure code must be in the ICD-PSC code Table.	16	MA66
w74	The Principal diagnosis code is missing on the claim	16	MA63
w75	The Principal procedure code contains an unnecessary digit.	16	MA66
w76	The Other diagnosis code is a duplicate of the Principal diagnosis code	16	MA64
w77	The Other diagnosis code is a duplicate of another Other diagnosis code on the claim.	16	M64
w78	Age conflict; the Admission diagnosis is not permissible for the patient's age.	9	
w79	Age conflict; the Other diagnoses is not permissible for the patient's age.	9	
w80	Age conflict; the Principal diagnosis is not permissible for the patient's age.	9	
w81	Gender conflict; the patient's gender and Admission diagnosis code, on the claim are not permissible.	10	N657
w82	Gender conflict; the patient's gender and other diagnosis code, on the claim are not permissible.	10	N657
w83	Gender conflict; the patient's gender and Other procedure code on the claim are not permissible.	7	
w84	Gender conflict; the patient's gender and Principal diagnosis code, on the claim are not permissible.	10	N657
w85	Gender conflict; the patient's gender and Principal procedure code, on the claim are not permissible.	7	
w86	Manifestation codes cannot be used as the Admission diagnosis.	16	MA65
w87	Manifestation codes cannot be used as the Principal diagnosis.	16	MA63
w88	Principal diagnosis code indicates a questionable admission.	16	MA63
w89	Diagnosis code is unacceptable as a principal diagnosis unless a required secondary diagnosis is included on the claim.	16	MA63
w90	Diagnosis code is unacceptable as a principal diagnosis.	16	MA63
w91	An E-code cannot be used as the Admission diagnosis code.	16	MA65

w92	An E code cannot be used as the Principal diagnosis code	16	MA63
	An E-code cannot be used as the Principal diagnosis code.		
w93	A non-covered over age 65 ICD procedure code is on the claim and the patient is older than 60 years of age.	6	N129
w94	Procedure code is non-covered when a designated diagnosis code is present.	11	
w95	Procedure code is non-covered unless the exemption ICD Procedure code or exemption ICD Diagnosis code is present.	96	N30
w96	Claim contains procedure codes that may be bilateral procedures: The documentation for procedures, should be reviewed.	16	N657
w97	Age invalid. Must be in range 0-124 years.	16	N329
w98	The patient gender is missing.	16	MA39
w99	The Patient Gender is invalid. Gender must be M, F, or U.	16	MA39
x07	This edit indicates that services essential to a procedure should not be separately coded.	234	M15
x08	This edit indicates that services essential to a procedure should not be separately coded.	234	M80
x09	This procedure is considered part of a more comprehensive procedure. The provider should submit the proper code.	234	M15
x10	This procedure is considered part of a more comprehensive procedure. The provider should submit the proper code.	234	M80
x11	This procedure is considered part of a more comprehensive procedure for this site. The provider should submit the proper code.	B15	M51
x12	This procedure is considered part of a more comprehensive procedure for this site. The provider should submit the proper code.	B15	M80
x13	This edit indicates that with and without codes should not be used together.	50	M51
x14	This edit indicates that with and without codes should not be used together.	B15	M80
x15	This edit indicates that anesthesia should not be reported separately when administered by the operating physician.	194	M80
x16	This edit indicates that anesthesia should not be reported separately when administered by the operating physician.	194	
x17	This edit indicates that individual lab tests should not be reported separately when a lab panel exists.	97	M15
x18	This edit indicates that individual lab tests should not be reported separately when a lab panel exists.	97	M15
x19	This edit indicates that only the code for the more invasive service should be reported.	50	M51
x20	This edit indicates that only the code for the more invasive service should be reported.	50	M51
x21	Preparation or monitor services that are integral to performance of the procedure should not be coded in addition to the procedure.	234	N390
x22	Preparation or monitor services that are integral to performance of the procedure should not be coded in addition to the procedure.	234	M15

x23 These codes should not be reported together per Current Procedural Terminology coding guidelines. 16 M81 x24 These codes should not be reported together per Current Procedural Terminology coding guidelines. 16 M81 x25 These codes should not be reported together per Current Procedural Terminology coding guidelines. 16 M81 x26 These codes should not be reported together per Current Procedural Terminology coding guidelines. 16 M81 x27 These codes should not be reported together per Current Procedural Terminology coding guidelines. 234 N20 x27 Certain services are not typically performed together. 234 N20 x28 Certain services are not typically performed together. 231 N20 x29 These codes indicate Mutually Exclusive Services considered reasonably impossible or improbable to perform on same patient at the same time. 231 x30 Codes indicate Mutually Exclusive Services considered reasonably impossible or improbable to perform on same patient at the same time. 231 x31 Two codes with opposing sex designations cannot be reported for the same patient visit. 7 x32 Two codes with opposing sex designations cannot be reported for the same patient visit. 108 N370 x33 This code wind the code is not valid or not valid for the service date on the claim line. 181 N325				
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This code violates age requirements of an applicable Local or National Coverage Determination Policy. X43 This code violates age requirements of an applicable Local or National Coverage Determination Policy. X44 This code violates gender requirements of an applicable Local or National Coverage Determination Policy. X46 This service lacks the required accompanying procedure according to a Local or National Coverage Determination Policy. X47 This service lacks the required accompanying procedure according to a Local or National Coverage Determination Policy. X48 Age invalid; not in range 0-124 years. X49 This edit occurred because the sex is invalid. It is not 1 or 2, M or F. X49 This edit occurred because the sex is invalid. It is not 1 or 2, M or F.	x40	This procedure code is not covered based on a statutory requirement.	96	N425
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This code violates gender requirements of an applicable Local or National Coverage Determination Policy. This service lacks the required accompanying procedure according to a Local or National Coverage Determination Policy. This service lacks the required accompanying procedure according to a Local or National Coverage Determination Policy. Age invalid; not in range 0-124 years. This edit occurred because the sex is invalid. It is not 1 or 2, M or F. 16 MA39	x42	This code violates age requirements of an applicable Local or National Coverage Determination Policy.	96	N115
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x48 Age invalid; not in range 0-124 years. x49 This edit occurred because the sex is invalid. It is not 1 or 2, M or F. 16 MA39	x46	This service lacks the required accompanying procedure according to a Local or National Coverage Determination Policy.	96	N115
x49 This edit occurred because the sex is invalid. It is not 1 or 2, M or F. 16 MA39	x47	This service lacks the required accompanying procedure according to a Local or National Coverage Determination Policy.	96	N115
	x48	Age invalid; not in range 0-124 years.	50	N129
x50 Invalid discharge disposition/patient status. 16 N50	x49	This edit occurred because the sex is invalid. It is not 1 or 2, M or F.	16	MA39
	x50	Invalid discharge disposition/patient status.	16	N50

x52	An emergency code cannot be used as a principal diagnosis.	146	MA63
x53	A manifestation code cannot be used as principal diagnosis.	146	MA63
x55	The principal diagnosis is invalid. The principal diagnosis indicates questionable admission.	146	
x56	The principal diagnosis is invalid. It is an unacceptable principal diagnosis.	146	MA63
x57	The principal Diagnosis is invalid because it is without the required secondary diagnosis.	146	MA63
x62	The patient age and diagnosis are inconsistent.	10	N657
x63	The patient gender and diagnosis are inconsistent.	10	N657
x64	The patient age and sex are inconsistent with the patient diagnosis.	10	N657
x66	An emergency diagnosis code cannot be used as an admitting diagnosis.	146	MA65
x67	A manifestation code cannot be submitted as admitting diagnosis.	146	MA65
x69	This diagnosis code is a duplicate of the principle diagnosis.	146	MA63
x70	The patient age and diagnosis are inconsistent.	10	N657
x71	The patient age and sex are inconsistent with the patient diagnosis.	10	N657
x72	The patient age and sex are inconsistent with the patient diagnosis.	10	N657
x74	This diagnosis code is a duplicate of another secondary diagnosis code on this claim.	146	M64
x76	The patient gender and procedure are inconsistent.	7	N115
x77	This procedure is not covered.	96	N30
x79	This procedure is covered in limited circumstances only.	59	
x82	The units are greater than one for a bilateral procedure with modifier 50.	16	M53
x83	Modifier FB submitted for a service which is not assigned to payment status S or T or V or X.	4	N519
x84	Revenue code 068X and Procedure code 99291 not submitted on the same date of service as G0390.	199	N657
x85	The claim lacks allowed accompanying procedure code for device.	16	M51
x86	This edit occurred because this claim is a possible duplicate of another claim.	18	N522
x89	Proposed alternate closed biopsy code.	59	

		1	1
x90	This edit occurred because the admitting diagnosis code is invalid.	16	MA65
x91	This edit occurred because the admitting diagnosis code is invalid It contains an unnecessary 4th or 5th digit.	16	MA65
x92	This edit occurred because the admitting diagnosis code is invalid. It has a missing 4th or 5th digit.	16	MA65
x93	Invalid patient admission date DX the patient admission date.	146	MA65
x94	Invalid DOA DX, 4th/5th digit date of admission. It contains an unnecessary 4th or 5th digit.	146	MA65
x95	Invalid DOA DX missing digit 4,5 date of admission. It has a missing 4th or 5th digit.	146	MA65
x96	This edit occurred because an invalid diagnosis code cannot be found on table of valid ICD-10-CM codes.	16	M76
x97	This edit occurred because the diagnosis code is invalid. It has an unnecessary 4th or 5th digit.	16	M76
x98	This edit occurred because the diagnosis code is invalid. It has a missing 4th or 5th digit.	16	M76
x99	This edit occurred because an invalid diagnosis code was found on ICD-CM table but is not valid for patient admit or discharge date.	146	M76
y01	The account ID field is missing or invalid.	16	N382
y03	The FTD edit validates the Admission and Discharge Dates at the Claim Level.	16	M52
y04	The CCA edit verifies that the condition codes on the claim are valid.	16	M44
y05	The PSC edit identifies claims that are missing or contains an invalid Patient Discharge Status Code.	16	MA43
y07	The TOB edit identifies claims that are missing or contains an invalid Type of Bill.	16	MA30
y08	The VAL edit confirms that the Value Codes on the claim are valid.	16	M49
y09	The ICMf edit validates that the claim contains the required primary diagnosis prior to HSS processing.	16	MA63
y10	The claim has a missing Patient ID. Analysis cannot be performed without a Patient ID.	16	N382
y11	The DOBf edit identifies a claim that has a missing or invalid DOB. Certain edits cannot be performed without the patient DOB.	16	N329
y13	This edit identifies a claim missing a Provider ID. Analysis cannot be performed without a Provider ID.	207	N257
y17	The SOA edit identifies claims that contain an invalid Source of Admission code.	16	MA42
y18	The TOA edit identifies claims that contain an invalid Type of Admission code.	16	MA41
y19	This edit identifies line items that are potentially duplicates when two lines entered on one or more claims are identical.	18	N522
y21	This edit identifies an entire inpatient claim that is a potential duplicate of a previously submitted inpatient claim.	18	N522

y23 This edit occurred because the first listed diagnosis field is blank or any diagnosis code is not valid for service dates on the claim. 146 M76 N75 y25 This edit occurred because the diagnosis code includes an age range and the patient age is outside of that range. 150 N837 y25 This edit occurred because the diagnosis code includes gender designation and the patient gender does not match. 150 N839 y27 This edit occurred because the diagnosis code includes gender designation and the patient gender does not match. 181 M20 y28 This edit occurred because the submitted procedure code is not valid to the service dates on the claim. 181 M20 y30 This edit occurred because the procedure code is not valid to the service dates on the claim. 181 M339 y31 This edit occurred because the procedure code is not valid to the service indicator meaning it is not covered. 96 N319 y32 This edit occurred because the procedure code has a noncovered service indicator meaning it is not covered. 96 N30 y33 This edit occurred because the procedure code has a noncovered service indicator. 96 N30 y34 This edit occurred because the procedure code has a questionable covered service indicator. 96 N30 y35 This edit occurred where multiple exclusive bilateral procedure codes a represent on same service date with or without modifier 50. 4 N519 y40 This edit occurred because the procedure codes as a questionable covered service indicator. 97 N77 y41 This edit occurred because Medicare designated procedure as pay status C meaning procedure is not covered when performed as outpatient. 97 M15 y41 This edit occurred because Medicare designated procedures were billed with same service date. 97 M15 y42 This edit occurred because the procedure is identified as a component of another procedure also on the claim for the same service date. 97 M15 y42 This edit occurred because the procedure is identi				
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	y51	This edit occurred because only incidental services were reported.	97	N20
y53 This edit occurred because the principal diagnosis is not related to mental health on a partial hospitalization claim. 16 MA63	y52	This edit occurred because procedure code indicator is Not Recognized.	16	N657
	y53	This edit occurred because the principal diagnosis is not related to mental health on a partial hospitalization claim.	16	MA63

y54 This edit occurred because ambulatory Payment Class 323 or 324 or 325 is present and three or more qualifying criteria are not present. y56 This edit occurred because a partial hospitalization claim is suspended for medical review and does not span more than three days. y57 This edit occurred because claims suspended for medical review and spans more than three days and mental health services not 57 percent. y58 This edit occurred because claims suspended for medical review and spans more than three days and mental health services not 57 percent. y59 This edit occurred because a mental health service assigned to Ambulatory Payment Class 323 or 324 or 325 does not exist. y59 This edit occurred because a mental health service assigned to Ambulatory Payment Class 323 or 324 or 325 does not exist. y50 Modifier 73 is present with an independent or conditional bilateral procedure with modifier 50 or a procedure with more than 1 unit. y52 This edit occurred because the claim contains an implanted device with no surgical or other service to implant the device. 16 M67 y63 This edit occurred because one of a pair of mutually exclusive procedures with same service date and no qualifying NCCI modifier. y64 This procedure is a component of another code on the claim without a qualifying NCCI modifier on the same day. y65 This procedure is a component of another code on the claim without a qualifying NCCI modifier on the same day. y66 This procedure is a component of another code on the claim without a qualifying NCCI modifier on the same day. y67 The edit occurred because this is not a valid revenue code. 16 M50 y68 POR Code 36430 requires a HCPCS code for the blood product to billed for the same date of service. y69 HCPC code 36430 requires a HCPCS code for the blood product to billed for the same date of service. y70 This edit occurred because Claims incredical visits are present on a separate procedure sist. y71 This edit occurred because staim condists entirely of a combination of lines that are der				
y57 This edit occurred because claims suspended for medical review and spans more than three days and mental health services not 57 percent. 16 N657 y58 This edit occurred because claims suspended for medical review and spans more than three days and mental health services not 57 percent. 16 N657 y59 This edit occurred because a mental health service assigned to Ambulatory Payment Class 323 or 324 or 325 does not exist. 16 N657 y61 Modifier 73 is present with an independent or conditional bilateral procedure with modifier 50 or a procedure with more than 1 unit. 4 N519 y62 This edit occurred because the claim contains an implanted device with no surgical or other service to implant the device. 16 M67 y63 This edit occurred because one of a pair of mutually exclusive procedures with same service date and no qualifying NCCI modifier. 4 N519 y64 This procedure is a component of another code on the claim without a qualifying NCCI modifier on the same day. 4 N519 y65 This procedure is a component of another code on the claim without a qualifying NCCI modifier on the same day. 4 N519 y66 This edit occurred because this is not a valid revenue code. 16 M50 y68 This edit occurred because multiple medical visits are present on the same day with the same Revenue Code without Condition Code GO. 16 M50 y69 HCPCs code 36430 requires a HCPCs code for the blood product to billed for the same date of service. 17 This edit occurred because multiple medical visits are present on the same day with those not represent an Observation service. 18 M51 y70 This edit occurred because Evices with service indicator C are present on a separate procedure list. y71 This edit occurred because Procedure code with a Procedure code with a status indicator of C. y72 This edit occurred because claim consists entirely of a combination of lines that are denied or rejected or are considered packaged. y73 This edit occurred because claim line contains a Procedure code with a status indicator of C. y75 This edit occurred because a claim	y54	This edit occurred because Ambulatory Payment Class 323 or 324 or 325 is present and three or more qualifying criteria are not present.	16	N657
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y73 This edit occurred because claim consists entirely of a combination of lines that are denied or rejected or are considered packaged. y74 This edit occurred because claim line contains a revenue code that requires a procedure code. y75 This edit is assigned to all other claim lines when one or more line contains a procedure code with a status indicator of C. y76 This edit occurred because a claim line contains a Procedure code which is noncovered by statute. y79 This edit occurred because observation codes G0243 or G0244 are billed on a claim with Type of Bill not equal to 13X. y80 This edit occurred because blood components that are not allowed to be coded together are reported on the same Date of Service. 97 N390 N20 N390	y71	This edit occurred because services with service indicator C are present on a separate procedure list.	96	M2
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y80 This edit occurred because blood components that are not allowed to be coded together are reported on the same Date of Service. 96 N56	y76	This edit occurred because a claim line contains a Procedure code which is noncovered by statute.	96	N425
	y79	This edit occurred because observation codes G0243 or G0244 are billed on a claim with Type of Bill not equal to 13X.	16	MA30
y81 This edit occurred because Procedure code starting with letter C is used without Bill Type 12X or 13X or 14X.	y80	This edit occurred because blood components that are not allowed to be coded together are reported on the same Date of Service.	96	N56
	y81	This edit occurred because Procedure code starting with letter C is used without Bill Type 12X or 13X or 14X.	16	MA30

This edit occurred because toole 60379 is present w/o code 60378 for same claim with bill type 13x y88 This edit occurred because code 60292 or 60293 or 60294 are on the claim and diagnosis V707 is not present as admit or second diagnosis. 16 M y86 This edit occurred because modifier CA is on 1 or more lines with indicator C and same service date or modifier CA with multiple units. 96 N y87 This edit occurred because procedure is not reportable on an Outpatient Prospective Payment System claim. y88 This edit occurred because Procedure G0129 Occupational Therapy is furnished as a component of partial hospitalization treatment program. 96 N y90 This edit occurred because Procedure G0129 Occupational Therapy furnished as a component of partial hospitalization treatment program. 97 This edit occurred because Procedure G0176 Activity Therapy furnished as a component of partial hospitalization treatment program daily. 98 This edit occurred because the line item contains a revenue code that is not recognized. 19 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval but is an unlisted code. 10 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. 98 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. 99 This edit occurred because the service was performed outside an approved clinical trial period. 99 This edit occurred because an procedure was not reported and 20 is not patient status code in form locator 22. 99 This edit occurred because an procedure was not reported with 1 or more associated device codes. 99 This edit occurred because approached was not reported with 1 or more associated device codes. 99 This edit occurred because approached was not reported with Revenue code 39X and modifier 8it without a line billed with Revenue Code 38X. 16 N This edit occurred because approached			T	
This edit occurred because procedure G0129 or G0293 or G0294 are on the claim and diagnosis V707 is not present as admit or second diagnosis. 16 M y86 This edit occurred because proc code reported has a status indicator C and same service date or modifier CA with multiple units. 96 N y87 This edit occurred because proc code reported has a status indicator of V indicating item can only be billed to DME Regional Carrier. 16 N y88 This edit occurred because procedure is not reportable on an Outpatient Prospective Payment System claim. 97 This edit occurred because Procedure G0129 Occupational Therapy is furnished as a component of partial hospitalization treatment program. 98 N y89 This edit occurred because Procedure G0129 Occupational Therapy is furnished as a component of partial hospitalization treatment program daily. y80 This edit occurred because Procedure G0129 Activity Therapy furnished as a component of partial hospitalization treatment program. y91 This edit occurred because the line item contains a revenue code that is not recognized. 10 N y92 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval but is an unlisted code. 11 N y93 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. y94 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. y95 This edit occurred because the service was performed outside an approved clinical trial period. y96 N y97 This edit occurred because modifier CA has been reported and 20 is not patient status code in form locator 22. y98 This edit occurred because a procedure was not reported with 1 or more associated device codes. y98 This edit occurred because a procedure was not reported with 1 or more associated device codes. y99 This edit occurred because a procedure was not reported with 1 or more associated device codes. y99 This edit occurred because a proce	y83	This edit occurred because no Evaluation Management visit the day of or day before the observation and date is December 31 or January 1.	96	N56
This edit occurred because the line item contains a revenue code that is not recognized. y82 This edit occurred because the line item contains a revenue code that is not recognized. y83 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. y84 This edit occurred because the service was performed outside an approved clinical trial period. y85 This edit occurred because the service was performed outside an approved clinical trial period. y86 This edit occurred because the service was performed outside an approved clinical trial period. y87 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. y88 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. y89 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. y80 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. y80 This edit occurred because the service was performed outside an approved clinical trial period. y80 This edit occurred because a procedure was not reported with 1 or more associated device codes. y80 This edit occurred because a procedure was not reported with 1 or more associated device codes. y80 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. y80 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. y80 This edit occurred because a procedure code was rosswalked to an appropriate anesthesia code. y80 This edit occurred because the anesthesia procedure code was performed by a non-anesthesia provider. y80 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. y80 This claim line is not reimbursed because more than one	y84	This edit occurred because code G0379 is present w/o code G0378 for same claim with bill type 13x	96	N56
This edit occurred because proc code reported has a status indicator of Y indicating item can only be billed to DME Regional Carrier. 16 N 17 Nis edit occurred because procedure is not reportable on an Outpatient Prospective Payment System claim. 18 Pay 17 This edit occurred because Procedure G0129 Occupational Therapy is furnished as a component of partial hospitalization treatment program. 19 N 10 N 11 This edit occurred because Procedure G0176 Activity Therapy furnished as a component of partial hospitalization treatment program daily. 10 N 11 This edit occurred because the line item contains a revenue code that is not recognized. 11 N 12 This edit occurred because C9399 was billed which is a drug that received Federal Drug Administration approval but is an unlisted code. 11 N 12 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. 13 N 14 N 15 Pay 17 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. 15 N 16 N 17 This edit occurred because the service was performed outside an approved clinical trial period. 17 Pay 17 This edit occurred because modifier CA has been reported and 20 is not patient status code in form locator 22. 18 N 18 N 19 This edit occurred because a procedure was not reported with 1 or more associated device codes. 19 This edit occurred because a procedure was not reported with 1 or more associated device codes. 10 The Account ID is missing. 11 The Account ID is missing. 12 This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Revenue Code 38X. 11 This edit occurred because blood products are billed with Revenue code was performed by a non-anesthesia provider. 12 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. 13 This claim line is not reimbursed because more than one anesthesia procedure c	y85	This edit occurred because code G0292 or G0293 or G0294 are on the claim and diagnosis V707 is not present as admit or second diagnosis.	16	MA65
This edit occurred because Procedure (30.29 Occupational Therapy is furnished as a component of partial hospitalization treatment program. 96 N 97 N This edit occurred because Procedure (30.129 Occupational Therapy is furnished as a component of partial hospitalization treatment program daily. 98 This edit occurred because Procedure (30.129 Activity Therapy furnished as a component of partial hospitalization treatment program daily. 99 N 90 This edit occurred because Procedure (30.129 Activity Therapy furnished as a component of partial hospitalization treatment program daily. 90 N 91 This edit occurred because the line item contains a revenue code that is not recognized. 91 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval but is an unlisted code. 91 N 92 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. 92 N 93 This edit occurred because the service was performed outside an approved clinical trial period. 94 This edit occurred because and office CA has been reported and 20 is not patient status code in form locator 22. 95 This edit occurred because a procedure was not reported and 20 is not patient status code in form locator 22. 96 N 97 This edit occurred because a procedure was not reported and 20 is not patient status code in form locator 22. 98 This edit occurred because a procedure was not reported and 20 is not patient status code in form locator 22. 99 This edit occurred because a procedure was not reported and 20 is not patient status code in form locator 22. 99 This edit occurred because and procedure code was a status indicator of M and it cannot be reported to the fiscal intermediary. 90 This edit occurred because and procedure code was a status indicator of M and it cannot be reported to the fiscal intermediary. 91 This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Rev	y86	This edit occurred because modifier CA is on 1 or more lines with Indicator C and same service date or modifier CA with multiple units.	96	N56
This edit occurred because Procedure G0129 Occupational Therapy is furnished as a component of partial hospitalization treatment program. 96 N 97 This edit occurred because Procedure G0176 Activity Therapy furnished as a component of partial hospitalization treatment program daily. 98 N 99 This edit occurred because the line item contains a revenue code that is not recognized. 99 This edit occurred because C9399 was billed which is a drug that received Federal Drug Administration approval but is an unlisted code. 99 This edit occurred because C9399 was billed which is a drug that received Federal Drug Administration approval but is an unlisted code. 99 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. 90 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. 90 N 91 This edit occurred because the service was performed outside an approved clinical trial period. 91 This edit occurred because modifier CA has been reported and 20 is not patient status code in form locator 22. 92 This edit occurred because a procedure was not reported and 20 is not patient status code in form locator 22. 93 This edit occurred because a procedure was not reported with 1 or more associated device codes. 94 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. 95 N 96 N 97 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. 98 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. 99 This edit occurred because the anesthesia procedure code was performed by a non-anesthesia provider. 90 The procedure code was crosswalked to an appropriate anesthesia code. 91 The Account ID is missing. 91 This claim line is being disallowed because the anesthesia procedure code was	y87	This edit occurred because proc code reported has a status indicator of Y indicating item can only be billed to DME Regional Carrier.	16	M51
This edit occurred because the service was performed prior to the date of Federal Drug Administration approval but is an unlisted code. 16 N 17 Nis edit occurred because the service was performed prior to the date of Federal Drug Administration approval but is an unlisted code. 18 N 19 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. 18 N 18 N 18 N 18 N 18 N 18 N 19 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. 96 N 19 This edit occurred because the service was performed outside an approved clinical trial period. 97 This edit occurred because approach to the service was performed outside an approved clinical trial period. 98 This edit occurred because approach to the service was performed outside an approved clinical trial period. 99 This edit occurred because approach to the service was performed outside an approved clinical trial period. 99 This edit occurred because approach to the service was not reported with 1 or more associated device codes. 90 This edit occurred because approach to the service with 1 or more associated device codes. 90 This edit occurred because approach to the service with 1 or more associated device codes. 90 This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Revenue Code 38X. 10 The Account ID is missing. 10 The Account ID is missing. 11 The Account ID is missing. 12 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. 19 N 10 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. 19 N 10 This service is not paid in addition to another anesthesia service on the same day.	y88	This edit occurred because procedure is not reportable on an Outpatient Prospective Payment System claim.	96	N56
y91 This edit occurred because the line item contains a revenue code that is not recognized. y92 This edit occurred because C9399 was billed which is a drug that received Federal Drug Administration approval but is an unlisted code. y93 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. y94 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. y95 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. y96 N y97 This edit occurred because the service was performed outside an approved clinical trial period. y98 This edit occurred because modifier CA has been reported and 20 is not patient status code in form locator 22. y97 This edit occurred because a procedure was not reported with 1 or more associated device codes. y98 This edit occurred because a procedure was not reported with 1 or more associated device codes. y99 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. y99 This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Revenue Code 38X. 16 N 201 The Account ID is missing. 16 N 202 The procedure code was crosswalked to an appropriate anesthesia code. 59 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. 204 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. 59 N 205 This service is not paid in addition to another anesthesia service on the same day.	y89	This edit occurred because Procedure G0129 Occupational Therapy is furnished as a component of partial hospitalization treatment program.	96	N56
This edit occurred because C9399 was billed which is a drug that received Federal Drug Administration approval but is an unlisted code. 16 N 18 N 1	y90	This edit occurred because Procedure G0176 Activity Therapy furnished as a component of partial hospitalization treatment program daily.	96	N56
y93 This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. y94 This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. y95 This edit occurred because the service was performed outside an approved clinical trial period. y96 This edit occurred because modifier CA has been reported and 20 is not patient status code in form locator 22. y97 This edit occurred because a procedure was not reported with 1 or more associated device codes. y98 This edit occurred because a procedure was not reported with 1 or more associated device codes. y98 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. y99 This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Revenue Code 38X. 16 No 201 The Account ID is missing. 16 No 202 The procedure code was crosswalked to an appropriate anesthesia code. 59 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. y96 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. 59 No 205 This service is not paid in addition to another anesthesia service on the same day.	y91	This edit occurred because the line item contains a revenue code that is not recognized.	16	M50
This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. 96 N 97 This edit occurred because the service was performed outside an approved clinical trial period. 98 N 99 This edit occurred because modifier CA has been reported and 20 is not patient status code in form locator 22. 99 This edit occurred because a procedure was not reported with 1 or more associated device codes. 90 N 91 This edit occurred because a procedure was not reported with 1 or more associated device codes. 91 N 92 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. 93 This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Revenue Code 38X. 10 N 11 The Account ID is missing. 11 The Account ID is missing. 12 The procedure code was crosswalked to an appropriate anesthesia code. 13 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. 14 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. 15 N 16 N 17 N 18 N 19 N 10 N 10 N 11 N 11 N 12 N 12 N 13 N 14 N 15 N 16 N 17 N 18 N 18 N 19 N 10	y92	This edit occurred because C9399 was billed which is a drug that received Federal Drug Administration approval but is an unlisted code.	16	N350
This edit occurred because the service was performed outside an approved clinical trial period. 96 No. 10	y93	This edit occurred because the service was performed prior to the date of Federal Drug Administration approval.	188	N386
This edit occurred because modifier CA has been reported and 20 is not patient status code in form locator 22. y97 This edit occurred because a procedure was not reported with 1 or more associated device codes. y98 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. y99 This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Revenue Code 38X. 16 N 201 The Account ID is missing. 16 N 202 The procedure code was crosswalked to an appropriate anesthesia code. 59 203 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. 204 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. 59 N 205 This service is not paid in addition to another anesthesia service on the same day.	y94	This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination.	96	N386
y97 This edit occurred because a procedure was not reported with 1 or more associated device codes. y98 This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. y99 This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Revenue Code 38X. 16 N 201 The Account ID is missing. 16 N 202 The procedure code was crosswalked to an appropriate anesthesia code. 59 203 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. 204 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. 59 N 205 This service is not paid in addition to another anesthesia service on the same day.	y95	This edit occurred because the service was performed outside an approved clinical trial period.	96	M61
This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary. 16 No. 16 No. 17 The Account ID is missing. 18 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. 19 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. 20 This service is not paid in addition to another anesthesia service on the same day.	y96	This edit occurred because modifier CA has been reported and 20 is not patient status code in form locator 22.	182	N657
y99 This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Revenue Code 38X. z01 The Account ID is missing. 16 N z02 The procedure code was crosswalked to an appropriate anesthesia code. z03 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. z04 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. z05 This service is not paid in addition to another anesthesia service on the same day. 59 N	y97	This edit occurred because a procedure was not reported with 1 or more associated device codes.	96	N56
z01 The Account ID is missing. z02 The procedure code was crosswalked to an appropriate anesthesia code. z03 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. z04 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. z05 This service is not paid in addition to another anesthesia service on the same day.	y98	This edit occurred because a procedure code has a status indicator of M and it cannot be reported to the fiscal intermediary.	16	M51
The procedure code was crosswalked to an appropriate anesthesia code. z03 This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. z04 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. z05 This service is not paid in addition to another anesthesia service on the same day.	y99	This edit occurred because blood products are billed with Revenue code 39X and modifier BL without a line billed with Revenue Code 38X.	16	M50
This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider. 204 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. 205 This service is not paid in addition to another anesthesia service on the same day. 206 Service is not paid in addition to another anesthesia service on the same day.	z01	The Account ID is missing.	16	N382
z04 This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service. z05 This service is not paid in addition to another anesthesia service on the same day. 59 N	z02	The procedure code was crosswalked to an appropriate anesthesia code.	59	
z05 This service is not paid in addition to another anesthesia service on the same day.	z03	This claim line is being disallowed because the anesthesia procedure code was performed by a non-anesthesia provider.	96	N95
	z04	This claim line is not reimbursed because more than one anesthesia procedure code was billed on the same date of service.	59	N633
706 This claim line is being disallowed because there is a missing or invalid beginning or ending date of service (DOS)	z05	This service is not paid in addition to another anesthesia service on the same day.	59	N633
200 This dain line is being distributed because there is a missing of mount beginning of chang date of service (bos).	z06	This claim line is being disallowed because there is a missing or invalid beginning or ending date of service (DOS).	16	MA31
z07 This line is eligible for a Bilateral Procedure Reduction.	z07	This line is eligible for a Bilateral Procedure Reduction.	59	N644

z08	The place of service code is missing or invalid.	16	M77
z09	The surgical procedure cannot be crosswalked to an anesthesia code without report.	252	M29
z10	This service is not normally performed for members in this age range.	6	N129
z11	This is a deleted or invalid code or modifier for this date of service . The provider should submit the proper code.	181	M20
z12	This is a deleted or invalid code or modifier for this date of service . The provider should submit the proper code.	181	M20
z13	This service is not covered for this member. The provider should submit the proper code or medical documentation.	7	N115
z14	Documentation is required when a modifier 59 is billed with the procedure code.	252	M127
z15	This is a duplicate of previous claim. If corrected billing please resubmit according to billing guidelines.	18	N522
z16	This claim line is being disallowed because the patients date of birth is missing, invalid, or after the date of service.	16	N329
z17	Claim line is being disallowed because number of units doesn't match the date span between the beginning and ending dates of service.	16	N345
z18	This is a duplicate of a previous claim. If corrected billing please resubmit according to billing guidelines.	18	N522
z20	This claim line is being disallowed because an E and M code is within the global period with a same Diagnosis category by same provider.	97	N525
z21	The procedure code on this claim line is retained from a transfer relationship.	97	M15
z22	Claim line is disallowed because a surgical code was submitted w/in the period w/a Dx from same category by the same provider.	97	N525
z23	A history claim line is disallowed because its procedure code is unbundled and is considered exclusive.	97	M80
z24	A history claim line is disallowed because its procedure code is unbundled and is considered unbundled.	97	M80
z25	A history claim line is disallowed because its procedure code is disallowed as part of a rebundle relationship.	97	M80
z26	A procedure code on a history claim line was part of a transfer relationship, but the procedure code was retained.	97	M15
z27	This condition is not normal for this patient age.	9	N657
z28	This service is not covered when performed for the reported diagnosis.	50	M64
z29	This service is not covered when performed for the reported diagnosis.	50	M64
z30	This claim line is being disallowed because there is no primary diagnosis code.	16	MA63
z31	The procedure can be crosswalked to two or more anesthesia codes and review is required to determine the appropriate code.	252	M29
z32	This claim line is being disallowed because diagnosis code requires a fourth and/or fifth digit to provide appropriate specificity.	16	M64

z33	The claim line contains an inappropriate modifier combination.	4	N519
z34	This is an invalid modifier for this date of service. The provider should submit the proper code.	4	N519
z35	This condition is not normal for this patient gender.	16	N657
z36	This procedure requires modifier 26 be billed.	16	N823
z37	Reimbursement for surgical assistant is not allowed on this procedure code.	54	N646
z38	This edit occurred because the Bilateral adjustment does not apply to this procedure code.	59	N644
z39	This is a bundled service. The payment is included in the service to which item or service is incident.	234	M15
		234	
z40	This is a bundled service. The payment is included in the service to which item or service is incident.		M15
z41	The provider who rendered these services is not eligible to assist during surgery.	96	N95
z42	This edit occurred because the procedure requires supporting documentation for an assistant surgeon.	252	M29
z43	This edit occurred because the procedure requires supporting documentation for a co-surgeon.	252	M29
z44	This edit occurred because the procedure requires supporting documentation for team surgery.	252	M29
z45	This procedure is redundant to the primary procedure and is limited by this member plan.	234	M15
z46	This service is a part of the original surgical procedure and is limited by this member plan.	234	M15
z47	This modifier is not compatible with this procedure code. The provider should submit the proper code.	4	N519
z48	This is a bundled service. The payment is included in the service to which item or service is incident.	234	M15
z49	This code or modifier or provider type is invalid.	16	N823
z50	This edit occurred because a non-covered service was submitted. The member is not liable for these charges.	96	N30
z51	This is a deleted or invalid code or modifier for this date of service The provider should submit the proper code.	4	N519
z52	This modifier is not compatible with this procedure code. The provider should submit the proper code.	16	N823
z53	This line is eligible for a multiple procedure reduction.	59	
z54	Physical therapy is not covered in this place of service. The member is not liable for these charges.	96	N428
z55	This service is a part of the original surgical procedure and is limited by this member plan.	97	M15
z56	This is a deleted/invalid code or modifier for this date of service. The provider should submit the proper code.	182	N657

±57 A claim line in history is disallowed because its procedure code is unbundled to a line on this claim. 234 M15 ±58 This procedure is considered part of the primary procedure and is limited by this member plan. 16 M61 ±60 This service is not covered when performed for the reported diagnosis. 816 M64 ±61 This procedure should not be billed since the member is an established patient. 816 N532 ±763 This claim line is being disallowed because the patient ID is missing or invalid. 4 N519 ±64 The place of service is not typical for the procedure code. 5 M77 ±65 This line is eligible for a Assistant/Co/Team Surgery modifier reduction. 45 N519 ±66 This procedure is considered part of the primary procedure and is limited by this member's plan. 97 M154 ±67 This claim line is being disallowed because the provider ID is missing or invalid. 207 N527 ±68 This claim line is being disallowed because the procedure code is disallowed as part of a rebundle relationship. 97 M343 ±70 This claim line is being disallowed because the procedure code is disallowed because the procedure code is unbundled and is considered evaluate.				
This service is not covered when performed for the reported diagnosis. 16 M64 261 This procedure should not be billed since the member is an established patient. 262 This claim line is being disallowed because the patient ID is missing or invalid. 263 This is a deleted or invalid code or modifier for this date of service. The provider should submit the proper code. 264 The place of service is not typical for the procedure code. 275 This line is eligible for a Assistant/Co/Team Surgery modifier reduction. 276 This procedure is considered part of the primary procedure and is limited by this member plan. 277 This service is a part of the original surgical procedure and is limited by this member plan. 278 This claim line is being disallowed because the provider ID is missing or invalid. 279 This is entire in the incidence of its being disallowed because the provider ID is missing or invalid. 270 This is claim line is being disallowed because the procedure code is disallowed as part of a rebundle relationship. 270 This is claim line is being disallowed because the procedure code is disallowed as part of a rebundle relationship. 271 This claim line is being disallowed because the procedure code one on typically allow an assistant surgeon modifier. 272 This claim line is being disallowed because the procedure code one on typically allow an assistant surgeon modifier. 274 This claim line is being disallowed because the procedure code is unbundled and is considered exclusive. 275 A transfer to an appropriate procedure code is unbundled and is considered exclusive. 276 This claim line is being disallowed because the procedure code is unbundled and is considered exclusive. 277 This claim line is being disallowed because the procedure code is unbundled and is considered exclusive. 278 This claim line is being disallowed because the procedure code is unbundled and is considered exclusive. 279 M80 278 This claim line is being disallowed because the procedure code is unbundled and is considered exclusive.	z57	A claim line in history is disallowed because its procedure code is unbundled to a line on this claim.	234	M15
this procedure should not be billed since the member is an established patient. 251 This claim line is being disallowed because the patient ID is missing or invalid. 252 This line is eligible for a Assistant/Co/Team Surgery modifier reduction. 253 This ine is eligible for a Assistant/Co/Team Surgery modifier reduction. 254 This procedure is considered part of the primary procedure and is limited by this member's plan. 257 This service is a part of the original surgical procedure and is limited by this member plan. 258 This service is a part of the original surgical procedure and is limited by this member's plan. 259 This service is a part of the original surgical procedure and is limited by this member's plan. 250 This service is a part of the original surgical procedure and is limited by this member's plan. 250 This schim line is being disallowed because the provider ID is missing or invalid. 250 This claim line is being disallowed because the procedure code is disallowed as part of a rebundle relationship. 251 This procedure does not normally require the services of an assistant surgeon. 252 This claim line is being disallowed because the procedure code does not typically allow an assistant surgeon modifier. 253 This edit occurred because a diagnosis code on the line is a possible third party liability. 254 This dit noccurred because and aganosis code on the line is a possible third party liability. 255 A transfer to an appropriate procedure coder is unbundled and is considered exclusive. 256 This claim line is being disallowed because the procedure code is unbundled and is considered unbundle. 257 This claim line is one in the interval of the procedure code is unbundled and is considered unbundle. 258 This procedure is considered cosmetic and is not a covered service under this member's plan. 259 This recedure is considered cosmetic and is not a covered service under this member's plan. 250 This procedure is considered investigative and is not a covered service under this member's plan.	z58	This procedure is considered part of the primary procedure and is limited by this member plan.	234	M15
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This is a deleted or invalid code or modifier for this date of service. The provider should submit the proper code. 5 M77 264 The place of service is not typical for the procedure code. 5 M77 265 This line is eligible for a Assistant/Co/Team Surgery modifier reduction. 45 266 This procedure is considered part of the primary procedure and is limited by this member plan. 97 M15 267 This service is a part of the original surgical procedure and is limited by this member's plan. 97 M144 268 This claim line is being disallowed because the provider ID is missing or invalid. 207 N257 269 The patient gender is missing or invalid. 16 MA39 270 This claim line is being disallowed because the procedure code is disallowed as part of a rebundle relationship. 97 M80 271 This procedure does not normally require the services of an assistant surgeon. 54 N646 272 This claim line is being disallowed because the procedure code does not typically allow an assistant surgeon modifier. 273 A transfer to an appropriate procedure occurred. This claim lines procedure was part of the transfer group. 275 A transfer to an appropriate procedure occurred. This claim lines procedure was part of the transfer group. 276 This claim line is being disallowed because the procedure code is unbundled and is considered exclusive. 277 This claim line is being disallowed because the procedure code is unbundled and is considered exclusive. 278 This claim line is being disallowed because the procedure code is unbundled and is considered unbundle. 278 This procedure is considered cosmetic and is not a covered service under this member's plan. 280 This procedure is considered investigative and is not a covered service under this member's plan. 281 N642 283 Bilateral Procedure Reduction	z61	This procedure should not be billed since the member is an established patient.	B16	
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z83 Bilateral Procedure Reduction 59 N644	z79	This procedure is considered cosmetic and is not a covered service under this member's plan.	96	N383
	z80	This procedure is considered investigative and is not a covered service under this member's plan.	55	N623
z84 Multiple Procedure Reduction 59	z83	Bilateral Procedure Reduction	59	N644
	z84	Multiple Procedure Reduction	59	

z88	This service is not covered when performed for the reported diagnosis.	16	M64
z89	This modifier is not compatible with this procedure code. The provider should submit the proper code.	96	N115
z90	This service is not covered when performed for the reported diagnosis.	50	M64
z91	This edit occurred because a primary diagnosis code is missing or invalid due to a Local or National Coverage Determination.	16	MA63
z92	This edit occurred because a secondary diagnosis code is missing or in valid due to a Local or National Coverage Determination.	16	M76
z93	This service is not covered when performed for the reported diagnosis.	16	M64
z95	The frequency and/or diagnosis does not meet policy requirements for procedure due to a Local or National Coverage Determination.	11	N386
z97	The place of service does not meet policy requirements for procedure code due to a Local or National Coverage Determination.	16	M77
z98	The patient's gender does not meet policy requirements due to a Local or National Coverage Determination.	16	MA39
z99	The age does not meet policy requirements for procedure or diagnosis due to a Local or National Coverage Determination.	50	N129