of Tennessee
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# 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 |
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| 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 | |

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| 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 |

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| 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 | |

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| 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 | |

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| 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 | |

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| 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. | B7 | |
| 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 | |
| B03 | 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 |
| B33 | 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 |

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| 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. | | |
| CBM | 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 |

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| 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. | 131 | |
| CMS | The provider has agreed to accept the amount allowed under this member's contract for this service. | 131 | |
| CO1 | This payment was secondary to primary benefits provided by this member's other health insurance. | 23 | |
| CO2 | This amount includes the benefits provided by this member's other insurance carrier. | 23 | |
| COB | Benefits cannot be provided until we receive previously requested information concerning this member's other insurance. | 22 | N197 |
| COS | This procedure is not eligible for benefits under this member's coverage because it was performed for cosmetic purposes. | 96 | N383 |
| CR | This member's coverage under this plan was not in effect on the date this service was provided. | 27 | N30 |
| CRT | CREDIT-ADJUSTMENT-OVERPAYMENT TO BE DEDUCTED FROM PAID AMOUNT. Message appears on RA when auto deduct of overpayment. | | |
| CVX | Coverage Exclusion | 96 | N30 |
| D01 | The dental allowable amount was increased. | 45 | |
| D02 | The dental allowable amount was decreased. | 45 | |
| D11 | The dental allowable amount per unit was increased. | 45 | |
| D12 | The dental allowable amount per unit was decreased. | 45 | |
| D13 | The dental allowable units were increased. | 45 | |
| D14 | The dental allowable units were decreased. | 45 | |
| D15 | This is the dental disallowed amount. | 96 | N130 |
| D21 | Please submit the date orthodontic treatment started. | | |
| DA0 | This dental claim is being adjusted since we have been notified that the provider billed for this service in error. | 169 | |
| DA1 | This claim was previously paid to the wrong provider. A payment has been made to the correct provider. | 169 | |
| 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 |
| EOB | 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 |

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| 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.) | | |
| G44 | This check amount is the outstanding balance (minus deductible and coinsurance) that the provider may bill. | 96 | N30 |
| GAR | Execution Of Garnishment | | |
| GLB | This claim is disallowed because it is included in the global case payment. | 97 | N525 |
| GNS | The provider must file this claim with Magellan, P.O. BOX 5190, Columbia, MD 21046. | 109 | N418 |
| 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 |

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| 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 |

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| MG6 | This service is not covered when performed for the reported diagnosis. | 11 | N657 |
| MG7 | The charge for this service has been combined with the primary procedure. | 234 | M15 |
| 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 | 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 | |

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| 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 | |
| O25 | 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. | | |

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| OOA | This claim was filed by an out of area dental provider. | | |
| OPT | Provider has opted out of Medicare. | 185 | |
| OTC | Drugs that can be purchased without a prescription are not an eligible expense. | 96 | N30 |
| OTc | 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 | |

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| 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 | |

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| 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 |

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| REJ | This service is not covered under this member's plan. | 96 | N30 |
| 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 |
| S2 | 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 |
| S3 | 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 |
| S5 | 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 |

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| 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. | B7 | |
| 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 |

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| 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 | |

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| 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 |

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| W59 | This claim was filed under the BlueCare provider number. Please resubmit using the Commercial provider number. | 16 | N77 |
| W5L | An ESRD claim must contain a diagnosis of End Stage Renal Disease. | 16 | M64 |
| 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 | 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 |
| W6L | 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 | This charge exceeds the maximum allowable under the group practice agreement. | 45 | |
| 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 | |
| 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 |

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| W80 | This member's benefits are based on Medicare's allowed amount. | 23 | |
| 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 |

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| WC2 | Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits. | 19 | N418 |
| WCS | Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits. | 19 | N418 |
| WD1 | This service is not eligible since it was not filed according to the corrected billing guidelines. Please submit a corrected claim. | 96 | N56 |
| WD2 | We are adjusting this claim because the procedure was billed in error. | 169 | |
| WD3 | The provider must refer to billing guidelines for BlueCare or TennCare Select. | 96 | N56 |
| 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-Here4TN) | 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 |
| WD8 | The documentation received with this claim is not legible. Please resubmit using legible copies. | 251 | N205 |
| WE0 | 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 | MA36 |
| WE4 | This charge was adjusted because we were notified that the provider billed for this service in error. | 96 | N10 |
| WE5 | This claim must be filed by the provider who actually rendered the service. | 96 | N32 |
| WE6 | This claim was paid to the wrong payee. | 129 | MA130 |
| WE7 | This charge has been forwarded to the member's appropriate pharmacy network to determine benefits. | 109 | N216 |
| WE8 | Benefits have been provided at the PCP Enhancement Rate. | 45 | |
| WE9 | The provider has agreed to accept the amount allowed under this member's contract for this service. | 45 | |
| 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 |
| 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 |

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| WL0 | This Home Health claim has a UB04 bill type other than 0322, 0327, 0329, 0332, 0337, 0339, or 034x. | 16 | MA30 |
| WL1 | This Home Health claim has an invalid service date, from -thru dates or admission date. | 16 | MA31 |
| WL2 | The length of stay for this Home Health Claim is greater than 60 days | 16 | MA31 |
| WL3 | The Home Health claim has more than one claim line with a HIPPS code and revenue code 0023. | 16 | N471 |
| WL4 | The Home Health claim indicates non-routine supplies were provided during the episode, without revenue code 027x or 0623. | 16 | M20 |
| WL5 | This Home Health claim is missing the Core Based Statistical Area in the UB-04 Value Amount with UB-04 Value Code 61. | 16 | M49 |
| 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 | N471 |
| 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. | 16 | MA41 |
| 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 | MA43 |
| WM5 | Statement from/thru dates must correspond service line dates of service before benefits can be provided. | 16 | MA31 |
| WM6 | Duplicate data not allowed in 5010 formatted claim. | 18 | N522 |
| WM7 | Member has other insurance; please bill the primary carrier.  Claim is paid due to the services being under the pay and chase option. | 22 | N598 |
| WM8 | This modifier code or procedure code is not valid for the date of service on the claim. | 4 | N519 |
| WM9 | This service is not covered when performed with an invalid diagnosis code. | 11 | N657 |
| 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 |
| 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 |

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| WN3 | This claim contains service dates that are invalid or out of range. | 16 | MA31 |
| WN4 | Only one Resource Utilization Group can be billed per individual date of service. | 16 | N471 |
| WN5 | SNF Part B claims are not allowed to cross the calendar year boundary. | 16 | M52 |
| WN6 | Part B therapy services billed with revenue codes 042x, 043x and 044x must be billed with the applicable modifier codes. | 182 | N657 |
| WN7 | This service is non-covered because authorization guidelines were not followed for this service. | 197 | |
| WN8 | The claim was adjusted following an external provider audit. | 50 | N10 |
| WN9 | The claim was adjusted following an external provider audit. | 50 | N10 |
| WOD | Payment of this claim is pending the receipt of a ownership and disclosure form from the rendering provider or group billing entity. | 16 | MA112 |
| WP0 | Call 1-800-924-7141 for claim detail if needed. | | |
| WP1 | This charge is being discounted in accordance with NPPN agreement. The member is not responsible for this amount. | 45 | |
| WP2 | This charge is being discounted in accordance with URN agreement. The member is not responsible for this amount. | 45 | |
| WP3 | This charge is discounted in accordance with MultiPlan Inc. agreement. The member is not responsible for this amount. | 45 | |
| WP4 | Benefits cannot be provided until the provider submits complete medical records for this inpatient admission. | 252 | N451 |
| WPX | Charges for a pre-existing condition are not eligible for benefits. | 51 | N607 |
| WQ0 | The number of units on this line is considered Medically Unlikely. | 96 | N362 |
| WQ1 | Automated Multi Channel Chemistry HCPCS component codes must have only one occurrence of a CD, CE or CF modifier on each line. | 16 | M53 |
| WQ2 | Automated Multi-Channel Chemistry service is not paid because less than 50% of these services are separately payable. | 234 | M15 |
| WQ3 | Telehealth originating site fee, HCPCS code Q3014, is billed incorrectly. | 16 | M20 |
| WQ4 | This service has been paid at a user-defined percent of charges. | 169 | |
| WQ5 | Claim lines for EPO and Aranesp must be billed with the proper revenue codes. | 16 | M50 |
| 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 |
| 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 |

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| 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 |

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| WT2 | This ancillary service is not eligible for reimbursement when billed with a triage visit. | 97 | M86 |
| WT3 | Benefits 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 | |
| WT5 | This emergency room service is included in the reimbursement for the observation room. | 45 | |
| WT6 | Payment has already been made by another TennCare coverage for these services. No additional reimbursement will be provided. | 129 | MA36 |
| 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 |
| WT8 | This is not a covered service since the primary carrier payment policies were not followed for this member. | 276 | N23 |
| 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 | | |
| WU0 | 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 | Line 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 | |
| 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 |

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| WX9 | 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 |
| WY0 | A corrected bill has been received.  Any previous payment from this is being recouped. | A1 | N770 |
| 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. | 133 | |
| WY3 | This edit occurred because a submitted procedure code is not valid for the service dates on the claim. | 181 | M20 |
| WY4 | Benefits cannot be provided until a special review is completed. | 133 | |
| WY5 | The provider has agreed to accept the amount allowed under this member's contract for this service. | 131 | |
| WY6 | The patient is not liable for these charges. | 133 | |
| WY7 | Provider is required to enroll in the Medicaid Program where the member resides. | B7 | N570 |
| WY8 | Provider is required to enroll in the Medicaid Program where the member resides. | B7 | N570 |
| WY9 | Medicaid Data Elements are Missing. | 252 | M127 |
| WZ0 | This provider has been termed per special review completed by BlueCross BlueShield of Tennessee. | 170 | |
| WZ1 | Payment of claim is pending receipt of Disclosure Form from the rendering provider or group billing entity. | 16 | MA112 |
| WZ2 | Claim did not meet the Tennessee Perinatal Care System for Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities. | 272 | N584 |
| WZ3 | Exceeds maximum units considered medically appropriate. | 119 | N435 |
| WZ4 | Medicare Advantage requires a completed CMS-2728-U3 form to be on file prior to adjudicating this claim. | 252 | M127 |
| WZ5 | Medicare Advantage requires a completed CMS-2728-U3 form to be on file prior to adjudicating this claim. | 252 | M127 |
| WZ6 | Statement from/thru dates must correspond service line date of service before benefits can be provided. | 16 | MA31 |
| WZ7 | A maximum of one Patient Assessment Form is payable each calendar year under this member's coverage. | 119 | N362 |
| WZ8 | Delivery charges for mother and baby must be billed separately. | 16 | MA36 |
| 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 |
| 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 |

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| 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 |

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| 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 |

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| 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 |

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| X88 | The provider must submit a correct procedure and place of service combination before benefits can be provided. | 5 | M77 |
| X89 | The submitted procedure is disallowed because an add on code was billed without the presence of the related primary service/procedure. | 97 | N122 |
| X90 | This modifier code or procedure code is not valid for the date of service on the claim. | 4 | N519 |
| X91 | Each per diem must be filed with any medication/injection. | 16 | M123 |
| X92 | Date span is not within Home Health Agency benefit week. | 199 | N657 |
| X93 | Date span is not within Home Health Agency benefit week. | 96 | N56 |
| X94 | Each per diem must be filed with any medication/injection. | 50 | M51 |
| X95 | A copy of pathology reports for the patient is needed before the claim can be considered. | 252 | M30 |
| X96 | Please submit a copy of the Explanation of Benefits from this member's other insurance carrier. | 252 | MA04 |
| X97 | Benefits cannot be provided until we receive previously requested information concerning this member's other insurance. | 252 | N686 |
| X98 | The submitted procedure is disallowed because an add on code was billed without the presence of the related primary service/procedure. | 97 | N122 |
| XA1 | This member's maternity benefits include a twelve-month waiting period before benefits can be provided. | 179 | |
| XA2 | Completed questionnaire is needed from the member before the claim can be processed. | 133 | |
| XA3 | This dental service is not eligible for benefits under this member's coverage. | 96 | N130 |
| XA4 | This service is not eligible because it was not rendered by this member's PCP. | 185 | 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. | 16 | 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 | M29 |
| XAR | Provider must submit a corrected bill with modifier for the destination before benefits can be provided. | 16 | N823 |

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| 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 | |

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| 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 | |
| XCB | Please refile this claim with the correct Explanation of Benefits from the other insurance carrier. | 16 | N4 |

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| 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 |
| XCP | 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 | |
| XCT | 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 |

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| XD2 | We are deducting this amount because of an overpayment on a previous claim. | 96 | N10 |
| XD3 | The provider must file this claim with the members home BlueCross BlueShield plan for processing. | 109 | N418 |
| XD4 | 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 these services for this member. | 119 | N640 |
| XD7 | This provider is not eligible under this member's coverage. | 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 |
| XDC | 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.  12121 N. Corporate Pkwy; Mequon, WI 53092 -  1-855-418-1623. | 109 | N418 |
| XDF | This expense is a duplicate of a previously submitted expense for this member. | 18 | N522 |
| XDH | Lifetime maximum or limit for Social Determinants of Health Pilot has been met or exceeded. | 35 | N117 |
| XDI | Modifier and procedure are incompatible with the Omnibus Budget Reconciliation Act of 1993. Please correct and resubmit. | 4 | |
| XDJ | Benefits exceed 30 day annual maximum. Please send in itemized charges per day for review. | 252 | N26 |
| XDK | Please resubmit claim with diagnosis for each prescribed drug. | 16 | M76 |
| XDL | Incorrect info submitted to Medicare. Please resubmit correct information to Medicare. | 16 | N480 |
| XDN | Newborn charges have been denied under the subscriber's name.  This newborn is not eligible for benefits. | 34 | |
| XDO | Newborn charges have been denied under the subscriber's name.  This newborn is not eligible for benefits. | 34 | |
| XDP | Please submit the original Medicare Explanation of Benefits showing the amount Medicare paid on this charge. | 252 | MA04 |
| XDQ | Inconsistent Provider Data. This claim will be reconsidered for benefits when provider data is corrected. | 16 | N290 |
| XDR | A copy of all diagnostic reports for the patient is needed before the claim can be considered. | 252 | N457 |
| 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 |

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| 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 |

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| 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. | B9 | |
| 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 | |
| XHB | 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 | |

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| 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 |
| XHJ | 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 | |

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| 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 | |
| XMH | 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 | |
| XOB | 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 |
| XPB | 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 |

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| 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 |

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| 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 |

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| 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 |

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| XSM | For services after 1/1/2000, this claim is administered by United Behavioral Health 1-877-237-8574. | 27 | N30 |
| XSN | Non-skilled nursing home visits are not a covered benefit under this plan. | B1 | N30 |
| 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 | N30 |
| XSV | This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan. | 97 | M80 |
| XSW | This service is not paid in addition to or separately from the primary service. | 234 | N20 |
| XSX | Facility claim is required to determine if nursery charges are routine or non-routine. | 252 | N706 |
| XSY | This charge is a duplicate of a previously submitted charge for this member. | 18 | N522 |
| XSZ | This service is considered part of the primary procedure. Please do not bill separately. | 97 | N19 |
| XSm | These services are handled by your Behavioral Health Provider. Please have your provider refile this claim with the appropriate carrier. | 96 | N30 |
| XT1 | This member's contract does not provide benefits for contraceptives. | 96 | 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. | 96 | 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 | N54 |
| XTD | A completed certificate of medical necessity that has been signed and dated by the ordering physician is needed. | 16 | M60 |
| XTE | Rendering facility's name, address, facility type, National Provider Identifier, and Tax Identification Number is needed. | 16 | N289 |

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| 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 |
| XTM | The provider must refer to the billing guidelines for proper billing. | 96 | 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 | |

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| 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 |

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| XVB | This service is considered part of a primary procedure. The member is not liable for this service under The No Surprise Act. | 97 | N860 |
| XVC | Qualified Payment Amount for out-of-network services under the No Surprises Act. Provider will receive details in a separate mailing. | 45 | N860 |
| XVD | No pricing found on the Medicaid fee schedule for the service billed. Therefore, this claim is applying zero payment. | 96 | 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 |

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| XVZ | Service is not eligible for payment based on the provider's contractual agreement. | 185 | |
| XW1 | Benefits for this service have a six-month waiting period. | 179 | |
| XW2 | Benefits for this service have a six-month waiting period. | 179 | |
| XW3 | Benefits for this service have a sixty-day waiting period. | 179 | |
| XWG | Medical records needed to make benefit determination. Please provide no later than 60 days from this notice. | 252 | M127 |
| XWH | The provider must submit a procedure code before benefits can be provided. | 16 | M51 |
| XWI | The provider must submit a copy of the manufacturer's invoice before benefits can be provided. | 252 | M23 |
| XWJ | Medical records needed from facility for inpatient stay. | 252 | M127 |
| XWP | This member's maternity rider includes a ten-month waiting period before benefits can be provided. | 179 | |
| XWS | Provider has opted out of Medicare. | 185 | |
| XWT | 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 |
| XWU | A diagnosis code which meets medical necessity for the procedure is missing or invalid. | 96 | N115 |
| XWV | Benefits cannot be provided for services that have been determined not to be medically necessary. | 50 | N130 |
| XWW | The provider must file this claim with CMS. The Medicare contractor to process this claim can be identified through the CMS website. | 109 | N104 |
| XWX | Exceeds maximum units considered medically appropriate. | 119 | N435 |
| XWY | Charges cannot be considered if the rendering provider's National Provider Identifier is not present on the claim. | 16 | N290 |
| XWZ | Charges cannot be considered if the rendering provider's National Provider Identifier is not present on the claim. | 16 | N290 |
| XX0 | Provider on Medicare's Preclusion List | 185 | |
| XX1 | Provider has opted out of Medicare. | 185 | |
| XX2 | This charge exceeds the maximum allowable under this member's coverage. | 45 | |
| XX3 | Hospice room and board claim is missing the nursing facility NPI or the NPI does not match state nursing facility rate sheet. | 16 | MA134 |
| XX4 | The claim for these services was received after the time limit specified in the provider's agreement. | 29 | |
| 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 |

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| 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. | B7 | |
| 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 |

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| 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 | |

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| 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. | | |
| 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 | Cost Share - Corrected - Additional Payment Made. | | |
| 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 | 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. | 169 | |
| 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. | | |
| ZOO | 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 |

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| 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 | |

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| ZYL | Place of service on this claim is inconsistent based on a previously filed claim that indicates service performed in a different setting. | 16 | M77 |
| ZYM | This procedure code was denied because it is considered to be included in the monthly rental fee of another procedure code. | 97 | N19 |
| ZYN | Benefits for this service are excluded under this member's plan. | 96 | N30 |
| ZYO | The billed diagnosis code was inappropriately coded based on ICD coding guidelines. | 16 | M64 |
| ZYP | The required modifier is missing or the modifier is invalid for the procedure code. | 16 | N823 |
| ZYQ | This charge was denied by Medicare and is not covered on this plan. The provider can bill the patient. | 96 | N30 |
| ZYR | This service is not covered when performed in this setting. | 96 | N428 |
| ZYS | This procedure code is not a billable service under this plan. | 96 | N431 |
| ZYT | The benefit for this service is included in the allowance for another service that has already been adjudicated. | 97 | |
| ZYU | The date of service is past timely filing guidelines. | 29 | |
| ZYV | This procedure was denied because it was billed by a provider with an invalid or inactive NPI number. | 16 | N433 |
| ZYW | Cosurgeons need to be of a different subspecialty. | 54 | N646 |
| ZYX | Each provider is reimbursed according to the portion of surgical care they provided during procedure(s). | B20 | M86 |
| ZYY | Procedure denied due to multiple submissions for the technical or professional component of the same procedure. | B13 | M86 |
| ZYZ | Contracted amount for procedure is greater than submitted charge. Payment reduced to the submitted charge. | 16 | M54 |
| ZZ1 | This CPT code has been denied because a more appropriate CPT code that  better describes the services rendered should be billed. | 96 | N56 |
| ZZ2 | This charge is a duplicate of a previously submitted charge for this member. | 18 | N522 |
| ZZ3 | This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan. | 97 | M80 |
| ZZ4 | This principle diagnosis code is invalid. The provider must submit a valid code. | 16 | MA63 |
| ZZ5 | This service is not normally performed for members in this age range. | 6 | N129 |
| 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 |
| 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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| ZZA | This is a bundled service.  The payment is included in the service to which item/service is incident. | 97 | M80 |
| ZZD | There are one or more edits present that cause this procedure to be denied. | 96 | N56 |
| ZZE | The billed service has been denied since the maximum units of service allowed has been exceeded. | 119 | N362 |
| ZZF | This is a bundled service. The payment is included in the service to which item or service is incident. | 234 | M15 |
| ZZG | Price adjusted due to additional line item modifiers. | 45 | |
| 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 |
| ZZJ | A potential overpayment has been identified on this claim. | 45 | |
| ZZL | 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 | N646 |
| ZZO | The submitted procedure is disallowed because it does not typically require a co-surgeon according to CMS Medicare guidelines. | 54 | N646 |
| ZZP | The submitted procedure is disallowed because it does not typically require a team of surgeons according to CMS Medicare guidelines. | 54 | N646 |
| 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 |
| ZZW | 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. | 97 | N525 |
| ZZX | This service is not paid in addition to or separately from the primary service. | 234 | N20 |
| ZZY | This health service code was denied as it is not a covered service when billed with the submitted diagnosis code. | 11 | N657 |
| p01 | A required procedure code or modifier is missing or invalid on the current line or an associated claim line | 16 | M67 |
| 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 |
| 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 |

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| 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 |

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| 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 |

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| 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 |

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| 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 |

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| 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 |

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| 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 |

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| w92 | An E-code cannot be used as the Principal diagnosis code. | 16 | MA63 |
| 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 |

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| 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 | Certain services are not typically performed together. | 234 | N20 |
| x28 | Certain services are not typically performed together. | 234 | N20 |
| x29 | These codes indicate Mutually Exclusive Services considered reasonably impossible or improbable to perform on same patient at 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 |
| x36 | This claim contains a statutory denied diagnosis and will be denied by Medicare. | 96 | N425 |
| x37 | This procedure code is not valid or not valid for the service date on the claim line. | 181 | |
| x38 | This procedure code is not valid or not valid for the service date on the claim line. | 181 | |
| x39 | This procedure code not currently covered. | 96 | N425 |
| x40 | This procedure code is not covered  based on a statutory requirement. | 96 | N425 |
| x41 | This service does not have a supporting diagnosis code under applicable medical necessity policy requirements. | 50 | M26 |
| x42 | This code violates age requirements of an applicable Local or National Coverage Determination Policy. | 96 | N115 |
| x43 | This code violates age requirements of an applicable Local or National Coverage Determination Policy. | 6 | N115 |
| x44 | This code violates gender requirements of an applicable Local or National Coverage Determination Policy. | 7 | N115 |
| x46 | This service lacks the required accompanying procedure according to a Local or National Coverage Determination Policy. | 96 | N115 |
| 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 |
| 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 |

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| 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 | |

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| 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 |

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| 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 |
| y24 | This edit occurred because the diagnosis code includes an age range and the patient age is outside of that range. | 9 | N657 |
| y25 | This edit occurred because the diagnosis code includes gender designation and the patient gender does not match. | 16 | MA39 |
| y27 | This edit occurred because external cause code cannot be primary diagnosis. | 146 | M76 |
| y28 | This edit occurred because the submitted procedure code is not valid for the service dates on the claim. | 181 | M20 |
| y30 | This edit occurred because the procedure code includes gender designation and the patient gender does not match. | 16 | MA39 |
| y31 | This edit occurred because the procedure code has a noncovered service indicator meaning it is not covered. | 96 | N115 |
| y32 | This edit occurred because Condition Code 21 indicates the provider is requesting verification of denial. | 96 | N30 |
| y33 | This edit occurred because the claim was submitted with Condition Code 20. | 16 | M44 |
| y34 | This edit occurred because the procedure code has a questionable covered service indicator. | 16 | N657 |
| y39 | This edit occurred where multiple exclusive bilateral procedure codes are present on same service date with or without modifier 50. | 4 | N519 |
| y40 | This edit occurred because Medicare designated procedure as pay status C meaning procedure is not covered when performed as outpatient. | 5 | M77 |
| y41 | This edit occurred because two mutually exclusive procedures were billed with same service date. | 234 | M80 |
| y42 | This procedure is one of a pair of mutually exclusive procedures and both codes exist on a claim with the same service date. | 234 | M15 |
| y43 | 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 |
| y44 | 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 |
| y45 | This edit occurred because one or more type T or S procedures are on same day as an Evaluation Management code without modifier 25. | 182 | N657 |
| y46 | This edit occurred because the modifier is not in the list of valid Outpatient Prospective Payment System modifiers. | 182 | N657 |
| y47 | Only edits for valid modifiers not specific to outpatient facility claims. | 182 | N657 |
| y49 | This edit occurred because the age is non-numeric or outside the range of 0-124 years. | 50 | N129 |
| y50 | This service is not covered for this member. The provider should submit the proper code or medical documentation. | 16 | MA39 |
| y51 | This edit occurred because only incidental services were reported. | 97 | N20 |
| 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 |

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| 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 |
| y56 | This edit occurred because a partial hospitalization claim is suspended for medical review and does not span more than three days. | 16 | N657 |
| 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 edit occurred because one of a pair of mutually exclusive procedures with same service date and no qualifying NCCI modifier. | 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 procedure is a component of another code on the claim without a qualifying NCCI modifier on the same day in history. | 4 | N519 |
| y67 | The 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 G0. | 16 | M44 |
| y69 | HCPCS code 36430 requires a HCPCS code for the blood product to billed for the same date of service. | 16 | M51 |
| y70 | This edit occurred because Observation Revenue code 762 is used with a Procedure code that does not represent an Observation service. | 199 | N657 |
| y71 | This edit occurred because services with service indicator C are present on a separate procedure list. | 96 | M2 |
| y72 | This edit occurred because Type of Bill 12X or 14X is present with Condition Code 41. | 16 | MA30 |
| y73 | This edit occurred because claim consists entirely of a combination of lines that are denied or rejected or are considered packaged. | 97 | N390 |
| y74 | This edit occurred because claim line contains a revenue code that requires a procedure code. | 16 | M20 |
| 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. | 96 | M2 |
| 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 |
| 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 |

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| 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 |
| y84 | This edit occurred because code G0379 is present w/o code G0378 for same claim with bill type 13x | 96 | N56 |
| 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 |
| 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 |
| 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 |
| y88 | This edit occurred because procedure is not reportable on an Outpatient Prospective Payment System claim. | 96 | N56 |
| y89 | This edit occurred because Procedure G0129 Occupational Therapy is furnished as a component of partial hospitalization treatment program. | 96 | N56 |
| y90 | This edit occurred because Procedure G0176 Activity Therapy furnished as a component of partial hospitalization treatment program daily. | 96 | N56 |
| y91 | This edit occurred because the line item contains a revenue code that is not recognized. | 16 | M50 |
| 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 |
| y93 | This edit occurred because the service was performed prior to the date of Federal Drug Administration approval. | 188 | N386 |
| y94 | This edit occurred because the service was performed prior to the effective date as specified in the National Coverage Determination. | 96 | N386 |
| y95 | This edit occurred because the service was performed outside an approved clinical trial period. | 96 | M61 |
| y96 | This edit occurred because modifier CA has been reported and 20 is not patient status code in form locator 22. | 182 | N657 |
| y97 | This edit occurred because a procedure was not reported with 1 or more associated device codes. | 96 | N56 |
| 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 |
| 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 |
| z01 | The Account ID is missing. | 16 | N382 |
| z02 | The procedure code was crosswalked to an appropriate anesthesia code. | 59 | |
| 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 |
| z05 | This service is not paid in addition to another anesthesia service on the same day. | 59 | N633 |
| 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. | 59 | N644 |

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| 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 |

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| 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 |
| z40 | This is a bundled service. The payment is included in the service to which item or service is incident. | 234 | 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 |

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| z57 | A claim line in history is disallowed because its procedure code is unbundled to a line on this claim. | 234 | M15 |
| z58 | This procedure is considered part of the primary procedure and is limited by this member plan. | 234 | M15 |
| z60 | This service is not covered when performed for the reported diagnosis. | 16 | M64 |
| z61 | This procedure should not be billed since the member is an established patient. | B16 | |
| z62 | This claim line is being disallowed because the patient ID is missing or invalid. | 16 | N382 |
| z63 | This is a deleted or invalid code or modifier for this date of service . The provider should submit the proper code. | 4 | N519 |
| z64 | The place of service is not typical for the procedure code. | 5 | M77 |
| z65 | This line is eligible for a Assistant/Co/Team Surgery modifier reduction. | 45 | |
| z66 | This procedure is considered part of the primary procedure and is limited by this member plan. | 97 | M15 |
| z67 | This service is a part of the original surgical procedure and is limited by this member's plan. | 97 | M144 |
| z68 | This claim line is being disallowed because the provider ID is missing or invalid. | 207 | N257 |
| z69 | The patient gender is missing or invalid. | 16 | MA39 |
| z70 | This claim line is being disallowed because the procedure code is disallowed as part of a rebundle relationship. | 97 | M80 |
| z71 | This procedure does not normally require the services of an assistant surgeon. | 54 | N646 |
| z72 | This claim line is being disallowed because the procedure code does not typically allow an assistant surgeon modifier. | 54 | N646 |
| z74 | This edit occurred because a diagnosis code on the line is a possible third party liability. | 20 | |
| z75 | A transfer to an appropriate procedure occurred.  This claim lines procedure was part of the transfer group. | 97 | M15 |
| z76 | This claim line is being disallowed because the procedure code is unbundled and is considered exclusive. | 97 | M80 |
| z77 | This claim line is being disallowed because the procedure code is unbundled and is considered unbundle. | 97 | M80 |
| z78 | This edit occurred because the procedure code is unlisted. | 16 | M51 |
| 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 |
| z83 | Bilateral Procedure Reduction | 59 | N644 |
| z84 | Multiple Procedure Reduction | 59 | |

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| 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 |