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 7/26/2023)

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

069	These expenses are not eligible since there is no money in your Flexible Spending Account.	187	
06D	This service was performed on a previously missing tooth.	272	
071	Your Dependent Care Flexible Spending Account funds have been exhausted. Payment may be made when additional funds are available.	187	
073	Benefits for this service are excluded under this member's plan.	96	N216
077	Long Term Care Hospital Override		
078	Claim Payment Level Override		
079	Line Item Denial Override		
07D	Benefits for this service are limited to two times per twelve-month period.	273	N412
082	Dual Secondary Processing Override		
084	UM Program ID Override		
08D	Services for hospital charges, hospital visits, and drugs are not covered.	96	N216
094	Sequestration		
09D	Services for premedication and relative analgesia are not covered.	96	N126
0DA	This is an adjustment to a previous dental claim that paid to the provider but should have paid to the subscriber.	169	
0s0	Change Secondary Coinsurance Amount		
0s1	Change Secondary Copay Amount		
104	This member's coverage excludes benefits for the condition for which this service was rendered.	96	N216
108	HHA NOA Exception		
10D	Benefits for sealants and dietary instruction are not covered.	96	N216
11D	The procedure code and tooth number filed do not correspond. An alternate procedure code was used for pricing.	169	
12D	Benefits for this procedure are limited to once per lifetime, per tooth and tooth surface.	119	N587
13D	Appliances due to wear and services to improve bite or to correct congenital or developmental problems are non-covered.	96	N216
14D	Benefits for implants, TMJ (Temporomandibular Joint) Dysfunction and periodontal splinting are not covered.	96	N216
15D	Benefits for this service are limited to one time per three-month period.	273	N435

16D	We cannot process this claim until we receive previously requested information concerning the member's other insurance.	22	
17D	Benefits for services that are considered to be primarily cosmetic are not covered.	96	N383
17d	A portion of these services is considered primarily cosmetic and will not be covered.	96	N383
18D	This procedure is not covered, an allowance for a standard procedure was paid.	169	
19D	Benefits for this service are limited to two times per calendar year.	273	N435
1DA	This dental claim is being adjusted due to a corrected billing submitted by the provider.	169	
1DO	Temporary procedure has been deducted from the amount of the primary procedure.	169	
1s1	Secondary Supplementation Amount		
201	Interest is being recouped.	85	
20D	Relines cannot be billed separately if done within six months of the primary denture and or partial procedure.	273	N435
217	Paid Limit Accumulator Has Been Altered by Med Supp Sequestration Reduced from the Paid Amount		
21D	Benefits for this service are limited to one time per sixty-month period.	273	N435
22D	Benefits for this service have a twenty-four month waiting period.	179	
23D	These benefits have been paid by the member's medical policy.	270	
24D	Benefits for this service are limited to one time per six-month period.	273	N435
25D	This category of dental benefits has a waiting period as specified in this member's dental contract.	179	
26D	Benefits for this service are limited to one time per five-month period.	273	N435
27D	Benefits for this dental service are not available, per this member's contract.	96	N216
28D	Benefits for this service are limited to one time per twelve-month period.	273	N435
29D	Benefits for this dental service are not available, per this member's contract.	96	N216
2s2	Secondary Allow Amount		
30D	This charge is a duplicate of a previously processed claim for this member.	18	N702
30d	This procedure is a duplicate of a previously filed procedure.	18	N522
31D	This service is denied based on information submitted. Participating dentist should charge only amount in 'Patient Owes'.	96	N10

328	This claim was adjusted to provide corrected benefits.	169	
32D	Benefits for this service are limited to one time per four-month period.	273	N435
330	Adjustment SF Pended		
331	Secondary Payor Pricing Qualifier		
33D	Benefits for this service are limited to one time per two-year period.	273	N435
341	HVA ASO Account Request	169	
342	Provider Audit	169	
343	This claim was paid to the wrong payee.	169	
344	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
345	Benefits for this service are excluded under this member's plan.	96	N30
346	Duplicate of previous claim. If corrected billing, please resubmit according to billing guidelines.	18	N702
347	Benefits for this service are excluded under this member's plan.	96	N30
348	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418
349	This claim was adjusted to provide benefits secondary to Medicare.	23	
34D	Benefits for this service have a ninety-day waiting period.	179	
350	This is a subrogation adjustment. It will not effect previously assigned patient liability.	215	
351	This claim was adjusted to provide benefits secondary to this member's other insurance coverage.	23	
352	This claim was previously processed under another member's name or ID number in error.	169	
353	This claim was previously processed under another member's name or ID number in error.	169	
354	This claim was adjusted to provide corrected benefits.	169	
355	This claim was adjusted to provide corrected benefits.	169	
356	This claim was adjusted to provide corrected benefits.	169	
35D	Benefits for this service are limited to one time per twenty-four month period.	273	N435
365	HVA Provider Audit	169	

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

39D	Benefits for this service are limited to one time per year.	273	N435
3s3	Supplemental Calculation Method		
40D	This date of service is after this member's termination date.	27	N30
41D	This service has been paid based on group's request.		
42d	McKee Executive Dental payment reimbursement		
43D	Processing of this claim is suspended awaiting information from the provider.	163	N686
44D	This charge exceeds the maximum allowable under this member's contract.	45	
46D	Processing of this procedure is suspended awaiting information from this member's medical or other carrier's policy.	22	
47D	Benefits for adult orthodontics are only payable for TMJ diagnosis.	96	N569
48D	Benefits for this service are limited to one time per forty-eight month period.	273	N435
50D	Benefits for this service are limited to three times per twelve-month period.	273	N435
51D	Grace period for plan limits.	45	
54D	Benefits for this service are limited to one time per calendar year.	273	N435
55D	Benefits for this service are limited to once per lifetime.	273	N435
56D	Benefits for this service are limited to four times per calendar year.	273	N435
57D	Benefits for this service are limited to one time per three-year period.	96	N130
57d	Benefits for this service are limited to one time per three calendar year period.	273	N435
58D	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	22	N4
59D	Benefits for this service are limited to one time per five-year period.	273	N435
60D	The combination of x-ray charges submitted on this claim should not exceed the cost of a full mouth series.	169	
61D	This allowance is based on a less costly procedure. The disallowed amount will be the patient's responsibility.	169	
62D	The combination of x-ray charges submitted on this claim should not exceed the cost of a full mouth series.	169	
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
AB0	Call 1-800-924-7141 for claim detail if needed.		
ABT	These digital services were provided by AbleTo, a BCBST vendor partner with zero cost share for this member.		
AD3	This is a subrogation adjustment. It will not affect previously assigned patient liability.	215	
AD4	This is the disallowed amount prior to subrogation adjustment.	215	MA67
ADP	This amount was previously paid to the wrong payee. A corrected payment has been made.	169	
ADT	This is an adjustment of a previously processed claim due to a BCBST change to the provider assignment.	169	
ADX	This claim was adjusted due to a change in provider information.	169	
AMB	Services are not covered under the payer's medical plan. Contact AmeriBen for additional information.	109	
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
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
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
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	
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
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
FEB	Please provide a revenue code that specifies the level of infant care provided.	96	N180
FED	Service is not covered unless obtained from a retail pharmacy.	96	N130
FEF	Service is not covered unless obtained from a retail pharmacy or Mail Service Drug program.	96	N130
FEL	Benefits not provided for deluxe lens features that are not medically necessary.	96	N30
FEM	Benefits not provided unless service is rendered in a Preferred facility with a Medicare Approved Transplant Program.	171	
FGE	This service is not normally performed for members in this age range.	6	N129

FGT	Member responsibility is limited on the difference between the allowed amount and this non-participating provider's billed amount.	45	
FHR	Benefits are provided for hearing aids, hearing aid dispensing fees, and supplies are limited to $2500 every five calendar years.	119	N640
FHS	Benefits are provided for hearing aids every five calendar years.	119	N417
FID	Patient cannot be identified as our insured based on the identification information billed on the claim.	31	
FIM	Submit Itemized bill on provider letterhead, including provider name, signature, professional status, and patient information.	252	N26
FMX	The maximum lifetime benefit has been met. Please contact your Specialty Drug Pharmacy Program at 1-888-346-3731.	149	N587
FNB	Routine newborn nursery charges are not covered because the mother is not an eligible member on this plan.	96	N30
FNC	Benefits not provided for charges that are scheduled or planned but not performed.	96	N658
FPC	This service is not covered when performed in this setting.	96	N428
FPD	The procedure is considered subset or redundant to the primary procedure and is limited by this member's plan.	97	M80
FPH	This member's coverage was not in effect prior to the dates of this hospital confinement.	26	
FPX	Benefits for this charge must be determined by filing through this member's appropriate pharmacy network.	109	N418
FRC	A detailed revenue code that identifies the specific service provided during the inpatient admission is required.	226	
FRX	This prescription should be submitted to Service Benefit Plan Retail Pharmacy Program. The customer service number is 1-800-624-5060.	109	
FSR	Benefits cannot be provided until a special review is completed.	133	
FTM	Benefits are not available for the costs associated with preventive telemedicine.	96	N776
FTP	Family therapy is a non-covered service.	96	N30
FX1	Supplemental Service may be Covered by the Member's Prepaid Flex Card.	109	N418
FX2	Supplemental Service may be Covered by the Member's Prepaid Flex Card.	109	N418
FYI	RECALCULATED PAYMENT - EXCLUDED FROM AMOUNT PAID. (Message appears on RA when auto deduct of overpayment.)		
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
LET	Benefits cannot be provided for this service. We are sending the member additional correspondence to explain.	200	
LMX	The maximum lifetime benefits payable under this member's coverage have been provided.	119	N587
LOV	This charge exceeds the maximum allowed under this member's coverage.	45	
M09	The provider has not contracted to provide this service.	96	N448
M19	Medicare cannot process a claim submitted by a beneficiary for a COVID-19 over-the-counter test.	96	N130
M47	This is a non-covered chiropractic service.	185	N684

MAD	This portion of your Medicare Part A deductible is not covered under your supplemental policy.	96	N30
MAR	Call 1-800-924-7141 for claim detail if needed.		
MAT	A portion of this claim is denied because this member was not eligible for benefits for the entire term of the pregnancy.	179	
MBC	Benefits are not available for these services when the benefit criteria is not met.	96	N130
MBD	This member's plan does not cover the Medicare Part B deductible.	96	N30
MBX	Member has Coordination of Benefits with Other Coverage agreement. Maximum benefits have been paid by other healthcare plan or Medicare.	119	
MCC	We cannot pay benefits until this member's out-of-pocket amount has been satisfied.	96	N30
MCD	This charge was denied by Medicare and is not covered on this plan. The provider can bill the patient.	96	N30
MCV	At home COVID tests are not a reimbursable expense.	96	N130
MDC	This amount exceeds the reimbursement due to Medicaid.	45	
MDN	Submit these services to the member's Dental Plan for further consideration.	109	N418
MDT	Submit these services to the member's Dental Plan for further consideration.	109	N418
MED	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	22	MA04
MG1	Duplicate of previous claim. If corrected billing, please resubmit according to billing guidelines.	18	N522
MG2	Benefits are provided for hearing aids, hearing aid dispensing fees, and supplies are limited to $2500 every five calendar years.	119	N640
MG3	Benefits are provided for hearing aids every five calendar years.	119	N417
MG4	Medical records have been requested from the provider.	252	M127
MG5	The provider must submit the primary diagnosis.	11	N657
MG6	This service is not covered when performed for the reported diagnosis.	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	
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
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
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
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.		
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	
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	
PED	Routine nursery or pediatric care of a newborn is not eligible for benefits.	96	N30
PEN	Benefits for this service have been reduced due to lack of compliance with plan requirements.	197	
PEO	This charge exceeds the maximum allowable under this member's coverage.	45	
PEX	This charge exceeds the maximum allowable under this member's coverage.	45	
PFC	This charge exceeds the maximum allowable under this member's coverage.	45	
PFS	This charge exceeds the maximum allowable under this member's coverage.	45	

PFU	This charge exceeds the maximum allowable under this member's coverage.	45	
PFV	This charge exceeds the maximum allowable under this member's coverage.	45	
PFW	This charge exceeds the maximum allowable under this member's coverage.	45	
PGA	This charge is not reimbursed according to your DRG contract. Please see the provider manual.	45	
PGD	This charge exceeds the maximum allowable under this member's coverage.	45	
PGE	This charge exceeds the DRG rate for this confinement.	45	
PGO	This charge exceeds the maximum allowable under this member's coverage.	45	
PGP	This charge exceeds the maximum allowable under this member's coverage.	45	
PGR	This charge exceeds the maximum allowable under this member's coverage.	45	
PHA	Pharmacological Management is non-covered.	96	N30
PHY	Physician fees should be filed separately from the hospital claim. The provider should rebill on the proper form.	89	N200
PI	Personal items cannot be considered for benefits.	96	N30
PLC	The Medicare limiting charge was applied.	96	N30
PLP	Percent Threshold Stoploss Met	119	
PMX	This charge exceeds the maximum allowable under this member's coverage.	45	
PPD	This service is included in the ordering physician's agreement. It should be billed to the ordering physician.	24	
PRO	Professional Pricer Reduction	45	
PS	This charge exceeds the maximum allowable under this member's coverage.	45	
PS0	Benefits for this service are excluded under this member's plan.	96	N30
PS1	The maximum amount payable under this member's coverage for this service has been provided.	119	N587
PS2	The maximum number of services payable under this member's coverage has been provided.	119	N362
PS3	Drugs that can be purchased without a prescription or other non-covered drugs are excluded under this member's plan.	96	N30
PS4	Maximum benefits payable under this member's coverage have been provided.	119	N587
PS5	Benefits for this service are excluded under this member's plan.	96	N30

PSB	This charge exceeds the maximum allowable under this member's coverage.	45	
PSC	This charge exceeds the maximum allowable under this member's coverage.	45	
PSM	This charge exceeds the maximum allowable under this member's coverage.	45	
PSR	This charge exceeds the maximum allowable under this member's coverage.	45	
PSS	This charge exceeds the maximum allowable under this member's coverage.	45	
PSU	This charge exceeds the maximum allowable under this member's coverage.	45	
PSV	This charge exceeds the maximum allowable under this member's coverage.	45	
PSW	This charge exceeds the maximum allowable under this member's coverage.	45	
PTR	The maximum number of units allowed for this service under this member's coverage has been provided.	119	N362
PX	Charges for a pre-existing condition are not eligible for benefits.	51	
PXN	NetworX Std Fee Schedule	45	
RB	These charges exceed the maximum room and board allowance under this member's coverage.	78	
RDP	This procedure is considered subset or redundant to the primary procedure and is limited by this member's plan.	97	M80
REC	MONEY RECEIVED - NO DEDUCTION FROM AMOUNT PAID. (Message appears on RA when auto recovery bypassed).		
REF	These services were provided after the time limit specified in the referral from the PCP or this member's plan.	95	N630
REJ	This 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
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
SE	This patient is not a covered member under the plan.	33	
SF	This patient is not a covered member under the plan.	33	
SG	This patient is not a covered member under the plan.	33	
SH1	This charge is a duplicate of a previously processed claim.	18	N522
SHD	This charge is a duplicate of a previously submitted charge for this member.	18	N522
SL	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SL2	This charge was discounted under the provider agreement. You have saved this amount by using a participating provider.	45	
SM	This member's coverage under this plan was not in effect on the date this service was provided.	13	
SN	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30

SN1	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SNF	The level of care billed does not match the level authorized. The provider must submit a corrected billing.	197	
SO	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SO1	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SP	This member's coverage under this plan was not in effect on the date this service was provided.	27	N619
SPD	Supplemental Discount	45	
SPL	This patients stop-loss limit has been reached. Benefits are payable at 100%.	119	
SPT	This member's coverage has terminated.	27	N30
SQ	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
ST	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
STN	This claim is pended due to non-payment of premiums. The member should contact his or her State Group Representative.	27	N30
STP	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
STU	Benefits cannot be provided until we receive information about this member's eligibility.	252	N375
SW	This member's coverage under this plan was not in effect on the date this service was provided.	27	N30
SW2	This is a non-billable service for the discipline level.	185	N684
SW3	This is a non-billable service for the discipline level.	185	N684
TF0	The claim for these services was received after the time limit specified in this member's benefit plan.	29	
TF1	The claim for these services was received after the time limit specified in the provider's agreement.	29	
TF3	The claim for these services was filed after the time limit for filing specified in this member's plan.	29	
TF4	Provider Med Supp Timely Filing Period Exceeded		
TF5	Adjustment Timely Filing Period Exceeded		
TF6	COB Timely Filing Period Exceeded		
TF7	Med Supp Timely Filing Period Exceeded		
TMF	The claim for these services was filed after the time limit for filing specified in this member's plan.	29	

TPS	Payments have been suspended at the direction of the Bureau of TennCare.	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
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
W14	This service should not be billed separately from the room and board.	234	M2
W15	This revenue code is not valid for place of service billed.	16	M50
W16	This is a non-covered service.	16	M12
W17	This service requires a detailed revenue code. The provider should refer to billing guidelines locator form 44.	16	M12
W18	This requires Case Management approval prior to rendering services.	197	
W19	The provider must submit a hard copy of this claim with outpatient medical records.	50	M127
W1L	The claim line contains revenue code 058x, 059x,0275,0276,0277,or 0278 with charges greater than zero or it has revenue code 0624.	16	M50
W1T	Benefits cannot be provided until completed consent form has been received for the Abortion, Sterilization or Hysterectomy review.	252	N3
W21	The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	189	M81

W22	This is not a valid revenue code for this provider. The provider should refer to billing guidelines.	16	M50
W23	This is an inactive revenue code. The provider should refile with a valid code.	16	M50
W24	This service requires a detailed revenue code. The provider should refer to billing guidelines locator form 42.	16	M50
W25	This revenue code is invalid for the place of service billed. The provider should verify this code.	16	M50
W26	The provider must refer to the billing guidelines for proper billing.	16	N657
W27	The facility has a separate contract for lithotripsy. When billing, the provider must use revenue code 790.	96	N56
W29	The facility did not contract for lithotripsy, revenue code 790. The provider must bill using revenue code 490 or 360.	96	N56
W2A	The provider must refer to the billing guidelines for proper billing.	96	N56
W2L	This claim contains injectable osteoporosis drugs that are not payable because the claim does not meet all of the required criteria.	50	N130
W30	This is a bundled service. The payment is included in the service to which item/service is incident.	97	M80
W31	Only the initial visit is eligible.	96	N113
W33	These charges were included in the reimbursement for the mother's room and board.	128	
W34	This is a deleted/invalid code or modifier for this date of service. The provider should submit the proper code.	182	N657
W35	These DRG outlier days were denied by Utilization Management.	69	
W36	These DRG inlier days were approved by Utilization Management.	69	
W37	This per diem rate was approved for this DRG facility transfer.	232	
W38	This amount was disallowed for this DRG facility transfer.	232	
W39	This DRG code is no longer valid.	A8	N657
W3L	This ESRD claim was billed with another bill type than 72x.	16	MA30
W40	A valid DRG code could not be assigned for the coding that was submitted. The provider must submit valid codes.	A8	N657
W41	Medical Direction of four or more concurrent procedures is not eligible for reimbursement.	B15	M80
W42	For dates of service prior to 1/1/01, please submit the claim to Magellan.	109	N418
W43	This procedure is considered investigative and is not a covered service.	55	N623
W44	Benefits cannot be provided for services that have been determined not to be medically necessary.	96	N30

W45	The claim for these services was filed after the time limit for filing specified in this member's plan.	29	
W46	The organ acquisition cost is included in the kidney transplant case rate.	97	N525
W47	This is a non-covered chiropractic service.	185	N684
W48	Benefits for maintenance or servicing of durable medical equipment within six months of purchase date are not available.	96	N30
W49	Benefits cannot be provided for this service because the required authorization or notification is not on file.	197	
W4L	ESRD claims must contain condition codes 59,71,72,73,74,76 or 80. Condition codes 73 and 74 cannot appear on the same claim.	16	M44
W50	Benefits cannot be provided for services that have been determined not to be medically necessary.	50	N130
W51	This code, modifier, or provider type is invalid. The provider should refer to billing guidelines.	96	N56
W52	The provider must submit this patient's complete medical history before benefits can be provided for this service.	252	M127
W53	This facility number is used only for Signature members. The provider must refile under the correct provider number.	16	N77
W54	The provider must submit this patient's medical records. Please reference this claim number and member id when you submit the records.	252	M127
W55	Benefits are unavailable until we receive the information we requested in a recent letter to the provider's office.	252	M143
W56	The provider must submit a letter of medical necessity and plan of treatment for this patient.	50	M135
W57	Information has been requested from another provider to completed a pre-existing review. Not action is required.	252	N204
W58	Interim bills should only be submitted once every thirty days for the same hospital stay.	16	M53
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
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
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	
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	
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
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
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	This claim was adjusted following an HDI provider Audit	50	N10
WN9	The claim was adjusted following an HDI 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
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
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
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
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
WZD	Improper or inappropriate use of the modifier billed with this procedure.	236	
WZE	Routine vision services should be filed to Eyemed for payment. We have forwarded your claim to EyeMed.	109	N418
WZF	CMHRS services are only billable through Magellan BH of VA. Re-submit to PO Box 1099; Maryland Heights, MO 63043.	109	N418
WZG	The member's Individualized Family Service Plan (IFSP) is not found or does not include this service.	284	M62
WZH	The member's Individualized Family Service Plan (IFSP) is not found or does not include this service.	284	M62
WZI	This service can only be billed with a professional modifier code and will not be reimbursed at the global or technical rate.	234	M15
WZJ	CMHRS services are only billable through Magellan BH of VA through 12/31/17. Re-submit to PO Box 1099; Maryland Heights, MO 63043	109	N418
WZL	This service was billed on the incorrect claim form type.	16	N34
WZM	This service was billed on the incorrect claim form type.	16	N34

WZN	Charges cannot be considered if the rendering provider's National Provider Identifier is not present on the claim.	16	N290
WZO	Frequency code 0 is handled as information only. Submit claim based on primary guidelines if member liability exists.	16	MA30
X01	The actual date of service is needed for this charge.	16	M52
X02	This charge should be filed at the time of delivery.	96	N56
X05	The provider must submit an itemized or detailed billing before benefits can be provided for this service.	252	N26
X06	The provider must submit the anesthesia time before benefits can be provided for this service.	16	N203
X07	The provider must submit the name and title of the individual who rendered this service before benefits can be provided.	16	N289
X08	The provider must submit a description of services rendered before benefits can be provided.	252	N350
X09	This principal diagnosis code is invalid. The provider must submit a valid code.	16	MA63
X10	DRG is not paid under the Acute Care Hospital Agreement.	45	
X11	The rate for this procedure was reduced based on the multiple surgery rule.	59	N644
X12	The provider has not contracted to provide this service.	185	N684
X13	This service is not paid in addition to or separately from the primary service.	234	N20
X14	This service is not covered for this member. The provider should submit the proper code or medical documentation.	16	MA39
X15	A valid DRG code could not be assigned for the coding that was submitted. The provider must submit valid codes.	236	N657
X16	The reimbursement for re-admission is included in the DRG allowance on a previous claim.	97	N525
X17	The provider must submit a correct procedure and revenue code combination before benefits can be provided.	199	N657
X18	This service is not normally performed for members in this age range.	6	N129
X19	Benefits have been reduced since the required authorization for this service was not obtained.	197	
X20	Benefits have been reduced since the required authorization for this service was not obtained.	197	
X21	These services were disallowed by Utilization Management.	39	
X22	Benefits for provider administered specialty drugs must be determined by filing through BCBST's pharmacy vendor.	109	N418
X23	Benefits for provider administered specialty drugs must be determined by filing through BCBST's pharmacy vendor.	109	N418
X29	This modifier is not compatible with this procedure code. The provider should submit the proper code.	4	N519

X30	Benefits cannot be determined until the provider submits the first date of dialysis.	16	MA122
X31	A split billing is needed for this confinement. The hospital must rebill according to the letter being sent to them.	96	N61
X32	The provider should refer to billing guidelines on filing days or units for Durable Medical Equipment claims.	108	N130
X33	The diagnosis code or procedure code is not valid for the date of service on the claim.	146	M76
X34	The provider must submit the x-ray report before benefits can be provided for this service.	252	M31
X35	The provider must file this claim with Magellan Health Services, PO Box 2154, Maryland Heights, MO 63043 (1-800-308-4934).	109	N418
X36	The provider must refer to the billing guidelines for proper billing of patient services.	96	N56
X37	Medical information is needed to complete a pre-existing review. Correspondence to the provider will follow.	252	N204
X38	Information has been requested from another provider to complete a pre-existing review. No action is required.	252	N204
X39	Pricing is based on a prior year agreement. The member is not liable for the amount that exceeds this pricing.	45	
X40	This amount represents your Medicare savings.	23	
X41	Submit English translation for each drug with an overseas claim form before benefits can be provided.	16	M123
X42	Submit an English version of Medical information before benefits can be provided.	16	N32
X43	Submit specific diagnosis code and overseas claim form before benefits can be provided.	16	MA63
X44	Submit clinical records and overseas claim form before benefits can be provided.	16	N163
X45	The provider needs to submit a statement of charges for each service with an overseas claim form before benefits can be provided.	16	MA31
X46	The provider needs to submit an itemized bill with an overseas claim form before benefits can be provided.	16	N34
X47	Provider needs to resubmit with charges itemized on a per day basis before benefits can be provided.	16	MA31
X48	The provider needs to submit itemized bill before benefits can be provided.	16	MA31
X49	Medical records have been requested for a provider audit reconsideration.	252	M127
X50	This amount was paid by your dental policy.	23	
X51	Vanderbilt employee PPO claims must be filed with Signature Health Alliance.	109	N418
X53	Benefits cannot be provided for services that have been determined not to be medically necessary.	50	N130
X54	This service is non-covered because authorization guidelines were not followed for this service.	197	

X55	The provider must file the claim with CareCentrix, PO Box 277947 Atlanta, GA 30384.	109	N418
X56	Medical records have been requested for a provider audit reconsideration.	252	M127
X57	The provider has agreed to accept the amount allowed under this member's contract for this service.	131	
X58	Medicaid Data Elements are Missing.	252	M127
X60	Benefits for services related to obesity, including surgical procedures, are not covered under this member's plan.	96	N30
X76	Medical records have been requested from the provider.	252	M127
X77	The provider must submit the NDC, drug name, RX number, strength, day supply and quantity before benefits can be provided.	16	M123
X78	The provider must refer to the billing guidelines for Home Infusion Therapy. A separate line must be billed for each date of service.	16	N61
X79	The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	189	M81
X80	This procedure requires an Origin and Destination modifier be billed. The provider should submit the proper code and modifier.	4	N519
X83	The provider must submit the proper code. No medication currently manufactured matching the code billed.	16	M119
X84	The date of birth follows the date of service.	14	
X85	The date of birth follows the date of service.	14	
X86	The provider must submit a correct procedure and revenue code combination before benefits can be provided.	199	N657
X87	The provider must submit a correct Type of Bill and revenue code combination before benefits can be provided.	16	MA30
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
XAT	Provider Audit Rec. - Call 423-755-5891		
XAX	Self-administered drugs not covered services under your plan.	96	N426
XAY	Self-administered drugs not covered services under your plan.	96	N426
XB0	This newborns date of birth and effective date are different, please contact the Department of Human Services.	26	N30
XB1	This member's plan does not cover a portion of the Medicare Part B deductible.	96	N30
XB2	Benefits for this service are excluded under this member's plan.	96	N30
XB3	Services for prenatal and postnatal care are not covered by this plan. Please re-file the labor and delivery charges only.	96	N188
XB4	We are deducting this amount because of an overpayment on a previous claim.	96	N10
XB5	Please submit a copy of the Medicare Explanation of Benefits so we can determine benefits.	252	MA04

XB6	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	252	MA04
XB7	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418
XB8	Your plan does not provide benefits for services by an out of network provider.	242	M115
XB9	Benefits cannot be provided for services not considered a medical emergency.	40	
XBA	These services should be filed and paid by the behavioral health carrier at ComPsych Claims, PO Box 8379, Chicago, IL 60680-8379.	109	N418
XBC	The provider must file this claim with Carelon Behavioral Health 1-888-474-0929.	109	N418
XBD	The provider must file this claim with OPTUM HEALTH SERVICES 1-855-437-3486 (1-855-Here4TN).	109	N418
XBE	Recoup due to Subrogation/Workers Comp Third Party Liability overpayment.	215	
XBF	The provider must submit a description of services rendered before benefits can be provided.	252	N350
XBG	The blood gases report is needed from the provider before benefits can be provided for these services.	252	N749
XBH	This is not a valid revenue code for this provider. The provider should refer to billing guidelines.	16	M50
XBI	Benefits are unavailable until we receive the information we requested in a recent letter to the provider's office.	252	M143
XBJ	The provider must submit the appropriate CDT/CPT/HCPCS code for this service.	189	M81
XBL	This is a possible duplicate claim line of another claim line in history.	18	N111
XBM	The date of service is past timely filing guidelines.	29	
XBN	This edit occurred because a submitted procedure code is not valid for the service dates on the claim.	181	M20
XBO	The claim has been identified as an inpatient readmission, payment has been reduced.	249	
XBP	Units/Days were limited by a Utilization Management authorization.	198	
XBQ	Medicare denied this charge and the provider cannot bill you for it.	45	
XBR	Qualified Payment Amount for out-of-network services under the No Surprises Act. Provider will receive details in a separate mailing.	45	N860
XBS	This procedure does not normally require the services of an assistant surgeon.	54	N646
XBT	Services for prenatal and postnatal care are not covered by this plan. Please re-file the labor and delivery charges only.	96	N188
XBU	This is a deleted/invalid code or modifier for this date of service. The provider should submit the proper code.	182	N657
XBV	This service is not covered when performed in this setting.	96	N428

XBW	This service is not covered when performed for the reported diagnosis.	11	N657
XBX	The provider has not contracted to provide this service.	96	N448
XBY	The Hospital Related Dates are Missing/Invalid.	16	N173
XBZ	Incorrectly submitted to BCBST. For providers par with BlueHPN, file with par BlueHPN plan. All others, file to member's plan.	109	N418
XC1	Benefits for compound drugs purchased from a non-participating pharmacy are not covered under this member's plan.	96	N30
XC2	The provider must file this claim with the members home BlueCross BlueShield plan for processing.	109	N418
XC3	Please refile this claim with the correct Explanation of Benefits from the other insurance carrier.	16	N4
XC4	Your plan does not provide benefits for services by an out of network provider.	242	M115
XC5	This amount includes the benefits provided by this member's other insurance carrier.	23	
XC6	This claim contains dates of service prior to program effective date.	26	N128
XC7	Qualified Payment Amount for out-of-network services under the No Surprises Act. Provider will receive details in a separate mailing.	45	N860
XC8	The provider must submit a correct condition code before benefits can be provided.	16	M44
XC9	The TOB edit identifies claims that are missing or contains an invalid Type of Bill.	16	MA30
XCA	The claim has been identified as an inpatient readmission, payment has been reduced.	249	
XCB	Please refile this claim with the correct Explanation of Benefits from the other insurance carrier.	16	N4
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
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	
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
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
XE1	The charges for the 2004 dates of service were forwarded to another BlueCross BlueShield plan for processing.	B11	
XE2	The provider needs to submit itemized bill, claim form, and Explanation of Benefits or rejection from other insurance.	16	N4
XE3	We cannot accept claim that has been altered. Please resubmit with corrected claim, medical records, and provider signature.	16	MA70
XE4	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	109	N36
XE5	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	129	N48
XE6	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	109	N36
XE7	The provider needs to submit statement from physician explaining why more than one physician was necessary with an overseas claim form.	16	N34
XE8	Please submit this claim to the local BlueCross and BlueShield plan where services were rendered.	109	N802

XE9	Benefits cannot be provided until the provider submits a Certificate of Medical Necessity.	251	M42
XEA	The provider must file separate claims with itemized bills for each family member. Please resubmit.	16	N63
XEB	Benefits cannot be provided until we receive previously requested information from the member.	16	N34
XED	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	252	MA04
XEG	A copy of the EEG report with analysis is needed before the claim can be considered.	252	M31
XEP	This service must be approved by your EAP.	197	
XF0	This service is non-covered when billed by a practitioner with this specialty.	170	N95
XF1	The claim was adjusted due to Maternity Incentive requirements were not met.	50	N10
XF2	Multiple transitional care management codes have been filed within a specific time period.	96	M86
XF3	The required modifier is missing or the modifier is invalid for the procedure code.	16	N519
XF4	This procedure is considered a part of the global package previously paid on another claim.	97	N525
XF5	The units billed on this claim fall outside the range of units that are considered medically appropriate.	151	N362
XF6	The claim was adjusted to reflect your payment to the Division of TennCare.	131	
XF7	A charge in history relating to this procedure has been paid. Please re-file corrected bill with all necessary charges on one claim.	97	M15
XF8	The ambulance report is needed from the provider before benefits can be provided for these services.	252	N745
XF9	This claim was previously processed under another member's name and/or ID number in error.	96	N10
XFB	This service is not covered because benefits for the related condition are limited by a rider to this member's contract.	51	N607
XFD	This contract does not provide benefits for services intended to create a pregnancy.	96	N30
XFE	Benefits cannot be provided because this provider is designated as a sanctioned provider by the Federal Government.	185	
XFF	Benefits are not available for this service because the type of hospice care cannot be determined.	282	MA30
XFG	Benefits cannot be provided until a special review is completed.	252	N439
XFO	Service ordered by provider sanctioned by HHS. Federal law mandates no payment when insured by federally funded program.	185	
XFS	Provider sanctioned by HHS. Patient insured by federally funded healthcare plan. Federal law mandates no payment.	185	
XFT	This contract does not cover infertility treatment, services to create a pregnancy, or any resulting complications.	96	N30

XFW	This is a subrogation adjustment. It will not affect previously assigned patient liability.	215	
XG0	Maximum benefits payable under this member's coverage have been provided.	119	N587
XG1	Benefits for this service are excluded under this member's plan.	96	N30
XG2	Please submit a copy of the Explanation of Benefits from this member's other insurance carrier.	252	MA04
XG3	This member's coverage was not in effect on the date this service was provided.	27	N619
XG4	This service is not covered because it is related to the member's employment.	96	N30
XG5	This service is not covered because it is related to the member's employment.	96	N30
XG6	This member's coverage was not in effect on the date this service was provided.	26	N30
XG7	This member's coverage was not in effect on the date this service was provided.	26	N30
XG8	This member's coverage was not in effect on the date this service was provided.	27	N619
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	
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
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	
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	
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
XPW	Benefits for this service have a ninety-day waiting period.	179	
XPX	Your coverage has a one-year waiting period before benefits are available for this service.	179	
XQ1	The ER level 5 (99285) has been recoded to level 4 (99284) based on claim information with clinical validation and reimbursed accordingly.	16	N56
XQA	Non-covered charge(s). Coverage Policy has not been approved by BCBST Pharmacy and Therapeutics Committee.	133	
XQB	Non-covered charge(s). Coverage Policy has not been approved by BCBST Pharmacy and Therapeutics Committee.	133	
XQC	The National Drug Code submitted on this claim is invalid. The National Drug Code must contain eleven alpha-numeric characters.	16	M119
XQD	We are deducting this amount because of an overpayment on a previous previous claim.	96	N10
XQE	We are deducting this amount because of an overpayment on a previous previous claim.	96	N10

XQF	Please submit a copy of the Medicare Explanation of Benefits (EOB) so we can determine benefits.	22	MA04
XQG	A detailed revenue code that identifies the specific service provided during the inpatient admission is required.	16	M50
XQH	Full aggregate amount allowed on previously processed claims. Patient is not liable for this charge.	234	M80
XQI	The provider has agreed to accept the approved aggregate amount allowed for this service.	131	
XQJ	This service is not covered when performed in this setting.	96	N428
XQK	The appropriate 340B modifier is required.	16	N822
XQL	Frequency code Alpha is handled as information only. Submit claim based on primary guidelines if member liability exists.	16	MA30
XQM	Some dates of service are not eligible for benefits. Submit claim including only the service dates the member is eligible for coverage.	239	
XQN	Benefits not provided for services and supplies with no charge or paid directly or indirectly by Local, State or Federal Government Agency.	96	M41
XQO	Provider to accept assignment of Medicare benefits. Patient not liable for difference between Medicare approved and actual charge.	96	M41
XQP	The level of the Evaluation and Management visit requires supporting documentation be submitted by the provider.	16	N56
XQQ	The units billed exceed the allowed amount for this procedure.	16	N430
XQR	This procedure was denied because the service is an incidental service that is not separately payable.	97	N390
XQS	The provider must submit a correct procedure and revenue code.	199	N657
XQT	The provider must submit an appropriately coded Evaluation and Management procedure.	16	N56
XQU	The National Drug Code submitted on this claim is invalid and/or not in effect for this date of service.	16	M119
XQV	Interim bill not acceptable for DRG pricing. Please submit all charges for this admission for benefit consideration.	16	M53
XQW	Payment is reduced because the diagnosis submitted on the claim is identified as a preventable emergency room diagnosis.	45	
XQX	The claim has been identified as an inpatient readmission, payment has been reduced by fifty percent.	45	
XQY	Discharge date is within 5 days of the admission date on a previously paid inpatient claim. Readmission is not eligible for reimbursement.	97	M86
XQZ	A detailed revenue code that identifies the specific service provided during the inpatient admission is required.	16	M50
XR0	Benefits cannot be provided since an authorization was not obtained for this service.	197	
XR1	This provider is ineligible to provide this pharmacy service.	185	N684
XR2	Diabetic Testing Supplies should be provided through Pharmacy.	109	N418

XR3	This medication is not covered under the member's medical plan. Please contact CVS Specialty at 1-888-265-7790 for pharmacy benefits.	185	N684
XRA	Payment is reduced because the diagnosis submitted on the claim is identified as a preventable emergency room diagnosis.	45	
XRB	Category III Codes allow zero payment if CMS does not establish a fee.	56	N623
XRD	Telehealth service filed without appropriate place of service or modifier.	5	M77
XRE	Please submit the name and National Provider Identifier of the rendering physician.	16	N277
XRF	The provider must submit this patient's medical records. Please fax to 1-888-535-5243 and reference the claim number and member ID.	252	M127
XRG	Category III Codes allow zero payment if CMS does not establish a fee.	56	N623
XRH	Telehealth service filed without appropriate place of service or modifier.	5	M77
XRI	Telehealth service filed without appropriate place of service or modifier.	5	M77
XRJ	Please resubmit claim with tooth number and/or surface for charge.	16	N37
XRK	The National Drug Code (NDC) does not match the procedure code filed on the claim.	16	M119
XRL	Need medical records showing record of a positive COVID-19 test.	252	M127
XRM	The claim is missing a gestational age diagnosis.	16	M64
XRN	The claim is missing a gestational age diagnosis.	16	M64
XRO	Medicare denied service due to inconsistent procedure, bill type, and place of service combination. Please confirm Medicare denial correct.	16	M77
XRP	Medicare's administrative process may not have been followed. Please confirm Medicare processes were followed and resubmit claim.	16	N480
XRQ	Patient's Medicare Beneficiary ID and Name received on the claim do not match. Please correct and resubmit.	16	MA92
XRS	Medicare denied pending corrected bill. Please resubmit your claim once Medicare has provided benefits.	16	N4
XRT	Pricing for this service was not found within fee schedules established for this provider.	96	N448
XRU	BlueCross BlueShield of Tennessee no longer administers claims for this group. Please contact employer for information.	27	N30
XRV	Please resubmit claim with a valid name and ID number for the other insurance carrier so that secondary payment can be determined.	251	MA04
XRW	The service billed must be filed to Medicare.	22	
XRX	This member's coverage does not provide benefits for prescribed drugs and other medications.	96	N30
XRY	Lifetime maximum or limit for Social Determinants of Health Pilot has been met or exceeded.	35	N117

XRZ	Provider has an agreement to file these services on a CMS1450 claim form.	234	N20
XS1	Secondary benefits will be paid until day one hundred of confinement. Benefits will then be based on medical necessity.	96	N30
XS2	The Bill type submitted on the claim is not compatible with the patient billed status.	16	MA43
XS3	These charges were included in the reimbursement for the mother's room and board.	128	
XS4	A new claim is being requested that meets Medicare payment guidelines. No action is required by the member.	96	N386
XS5	Oral/Self-administered medications are not covered.	96	N426
XS7	The provider has not contracted to provide this service.	96	N448
XS8	This procedure is considered investigative and is not covered under this member's plan.	55	N623
XS9	The required Supervising Physician is missing, invalid, or not on file with BlueCross BlueShield of Tennessee.	16	N297
XSA	This is money reimbursed due to another party's payment. Refer to Patient Owes column for any liability changes.	215	
XSB	This amount exceeds the member's liability per Health Care Financing Administration guidelines.	45	
XSD	We are providing secondary benefits to your prescription drug card.	23	
XSF	This coverage does not provide benefits for the treatment of self inflicted injuries.	96	N30
XSH	This amount was applied to the member's monthly patient pay.		
XSI	This coverage does not provide benefits for the treatment of self inflicted injuries.	96	N30
XSJ	The required Supervising Physician is missing, invalid, or not on file with BlueCross BlueShield of Tennessee.	16	N297
XSM	For services after 1/1/2000, this claim is administered by United Behavioral Health 1-877-237-8574.	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
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
XUC	This charge exceeds the maximum allowable under this member's coverage.	45	
XUE	The accident date is needed before benefits can be determined for this service.	16	N305
XUF	Benefits available for interpretation of test results only if the test is covered. Claim for Sleep Study not on file and must be submitted.	B15	N674
XUN	This claim was for date of service July 1, 2015, or after, please submit to new Claims Administrator.	27	N30
XUQ	The service billed must be filed to Medicare.	22	
XUS	This modifier code or procedure code is not valid for the date of service on the claim.	4	N519
XUT	Please sign this form and resubmit it to the address shown on this form.	251	MA75
XUU	Services do not usually require an anesthesiologist. If there were unusual circumstances, please submit additional information.	252	N706
XUV	Not a Medicare recognized provider type for benefit coverage for this service.	170	
XUW	Not a Medicare covered benefit.	96	N569
XUX	Need evidence of supervising physician or chiropractor.	16	N296

XUY	Benefits are not paid for services or supplies billed in advance. Please submit a claim after you receive the services or supplies.	110	
XUZ	Benefits are excluded for an on the job injury or for services eligible for Worker's Compensation benefits.	19	N418
XV0	Services are not authorized for the level of care billed.	197	
XV1	Benefits for this service are limited to one time per twelve-month period.	119	M90
XV2	Benefits for this service are limited to one time per twenty-four month period.	119	N435
XV3	The onset of Illness or symptom cannot be the same as the date of service on the claim.	16	MA100
XV4	A correctly completed consent form is required from the provider before this service can be considered for benefits.	251	N28
XV5	A correctly completed consent form is required from the provider before this service can be considered for benefits.	251	N28
XV6	Medicaid claims must be submitted within three years from the date of service to be considered for payment.	29	
XV7	The billed diagnosis code was inappropriately coded based on ICD coding guidelines.	16	M64
XV8	The rendering provider is not eligible to perform the service billed.	185	N570
XV9	Service not payable when billed with a date span. Detailed billing is required to adjudicate this claim/service.	252	N26
XVA	Qualified Payment Amount for out-of-network services under the No Surprises Act. Provider will receive details in a separate mailing.	45	N860
XVB	This service is considered part of a primary procedure. The member is not liable for this service under The No Surprise Act.	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
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
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
XY2	Procedure disallowed because split billing was detected. Services on the same day should be filed on a single claim.	A1	N149
XY3	This procedure is considered investigative and is not covered under this member's plan.	55	N623
XY4	The procedure is considered subset or redundant to the primary procedure and is limited by this member's plan.	97	M80
XY5	The maximum lifetime benefits payable under this member's coverage for this procedure have been provided.	119	N587
XY6	The provider has not contracted to provide this service.	96	N448
XY7	Benefits are not available for these services when the benefit criteria is not met.	96	N130
XY8	Your payment is being withheld in accordance with a regulatory notice. Refer to your letter of payment suspension for more information.	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
XYR	This edit occurred because only incidental services were reported.	97	N20
XYS	DMAS requires Physician Assistant services to be billed under the supervising physician. Consult DMAS regulations for more information.	185	N95
XYT	Provider's charges are covered under a capitation agreement with our plan.	24	
XYU	Provider's charges are covered under a capitation agreement with our plan.	24	
XYV	We received a Medicare claim for processing; however, because you do not have any liability for this service, we will not provide benefits.	96	M41
XYW	Benefits for provider administered specialty drugs must be billed by a BlueCare Tennessee participating specialty pharmacy provider.	109	N418
XYX	This service requires Electronic Visit Verification information to be billed on the 837P submission.	16	MA114
XZA	Paid according to the USA MCO/USA Senior Care Network contractual agreement.	1	N364
XZF	Hospice room and board charges must be billed by the Skilled Nursing facility.	16	MA30
XZG	Oral/Self-administered medications are not covered.	96	N426
XZH	Benefits for provider administered specialty drugs must be billed by a BlueCare Tennessee participating specialty pharmacy provider.	109	N418
XZI	The provider must submit a correct procedure and place of service combination before benefits can be provided.	5	M77

XZJ	Benefits for provider administered specialty drugs must be billed by a BlueCare Tennessee participating specialty pharmacy provider.	109	N418
XZK	These charges cannot be considered for payment since Medicare has denied the service as an exact duplicate of a previously paid claim.	276	
XZL	Benefits cannot be provided for this service because the required authorization or notification is not on file.	197	
XZM	The units of service billed for the procedure code exceeds the allowed number of units.	50	N362
XZN	These charges cannot be considered for payment until Medicare completes their review and makes a final benefit determination.	276	
XZO	These charges cannot be considered for payment until Medicare receives the information needed to completed their benefit determination.	276	
XZP	The required modifier is missing or the modifier is invalid for the procedure code.	16	N823
XZQ	Provide rationale as to why the sleep study was performed in a lab.	5	
XZR	Please submit the facility claim for the mother's maternity stay and resubmit the newborn claim.	B16	
XZS	Please provide a revenue code that specifies the level of infant care provided.	16	M50
YAB	This claim was adjusted because the service is eligible for benefits under the member's coverage.	169	
YAI	This claim was adjusted because additional information was received.	169	
YBC	This claim was adjusted because the provider submitted a corrected billing.	169	
YBE	This claim was adjusted because we were notified that the provider billed for this service in error.	169	
YBI	This claim was adjusted to include the additional billing from the provider.	169	
YCA	Cost Share - Corrected - DO NOT ADJUST.		
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	
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
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
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	
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
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
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	
s11	Non-exempt facility submitted Non-exempt diagnosis w/POA of 1 or X	16	N434
s12	The Principal Diagnosis code requires a non-exempt POA indicator of 1 or X	16	N434
s13	The Other diagnosis code requires a non-exempt POA indicator of 1 or X	16	N434
s14	Non-exempt facility submitted other diagnosis code with Hospital Acquired Condition	233	
t02	The required procedure code is missing according to a Local Coverage Determination.	16	M51
t03	The provider specialty does not meet criteria for the procedure code according to a Local Coverage Determination.	8	MA130
t04	Add-on procedure code billed with primary procedure on Claim-Id Line.	16	MA66
t05	History Procedure Code has incidental relationship with this procedure code.	97	M80
t07	The diagnosis on the line is inconsistent with the procedure according to a Local Coverage Determination.	11	N657
t08	This edit occurred because the procedure has a profile relationship according to the Local or National Coverage Determination.	96	N386
t09	This procedure requires documentation according to a Local Coverage Determination.	252	M127
t10	This add-on procedure is not eligible when the primary procedure is not eligible.	B15	N674

t11	Bilateral Procedure reduction.	59	N670
t12	Procedure code and history procedure code indicate multiple imaging services. A 25% reduction of the technical component applies.	59	
t13	Procedure code and history procedure code indicate multiple imaging. 25% reduction of the technical component applies.	59	
t14	This procedure is missing an appropriate modifier when related to an evaluation and management visit in patient history.	16	N823
t15	This procedure is missing an appropriate modifier when billed with an evaluation and management code.	16	N823
t18	The maximum frequency for this procedure code has been exceeded.	119	N362
t19	A multiple procedure reduction of 50 percent of the allowed amount should be applied to this claim line.	59	N670
t20	An operative report must be reviewed when more than 5 procedures have been performed on the same date of service.	252	M29
t21	A multiple procedure reduction of 50% of the allowed amount should be applied to History Claim.	59	
t22	An add on procedure code has been submitted without the appropriate primary procedure.	B15	N122
t23	Procedure code is a non-covered service per the Non-covered Service list.	96	N30
t24	Add-on procedure code has been submitted without an appropriate primacy procedure code.	B15	N122
t25	Procedure Code has an incidental relationship with another procedure code.	97	M80
t26	Only intraoperative portion of global payment is allowed.	59	
t27	Only postoperative portion of global payment is allowed.	59	
t28	Only preoperative portion of global payment is allowed.	59	
t29	Only intraoperative portion of global payment is allowed.	59	
t30	Per Medically Unlikely Edits, the units of service billed for this procedure code exceeds the allowed units.	96	N362
t31	The presence of an anesthesia modifier indicates a reduction in payment.	59	
t32	Anesthesia code on this line requires an appropriate modifier.	4	N519
t33	This edit occurred because a professional component modifier is needed for this place of service for this diagnostic procedure code.	4	N519
t34	The procedure code describes the physician service. Use of modifier ZY is not appropriate.	4	N519
t35	This procedure code describes only the technical portion of a service or diagnostic test. Modifier ZY is not appropriate.	4	N519
t36	The procedure code describes the global code of a service or diagnostic test. Modifier ZY is not appropriate.	4	N519

t37	The procedure code describes a physician interpretation for service and is not appropriate in place of service.	96	M97
t38	The procedure code is a service covered incident to a physician's service and modifier XY is not appropriate.	4	N519
t39	The procedure code is a service covered incident to a physician's service and modifier YZ is not appropriate.	4	N519
t40	The use of a modifier is not typical for the billed procedure.	4	N519
t41	This procedure was performed on the same day of a history procedure by the same provider. The diagnosis indicates same condition.	96	M86
t42	Items that do not have a physician order or prescription are not covered.	173	N667
t43	The ESRD Supply HCPCS code billed is not Payable to DME Suppliers.	96	N95
t44	The maximum frequency for the DME procedure code has been exceeded	96	N435
t45	The procedure was performed on the same day of a history procedure by the same provider. The diagnosis indicates condition	96	M86
t46	A diagnosis code or codes which meets medical necessity for the procedure code is missing or invalid.	146	M76
t47	A history procedure code by the same provider is in the global period of the procedure code for the same condition	96	M86
t48	A diagnosis code, which meets medical necessity for the procedure code is missing or invalid.	146	M76
t49	All claim lines on the same claim must contain the modifier EY.	4	N519
t50	Modifier GK cannot be submitted alone, another line with GA or GZ must be present on the same claim.	4	N519
t51	Item or service statutorily excluded or does not meet the definition of any Medicare benefit.	4	N519
t52	The procedure code is a non covered code or the modifier is a non covered modifier.	16	N657
t53	These are non-covered services because this is not deemed a medical necessity by the payer.	50	
t54	A diagnosis code, which meets medical necessity for the procedure code is missing or invalid.	146	M76
t55	In the absence of injury or direct exposure, preventive immunization and its administration is not covered.	50	N130
t56	A history procedure code is within the global period of the procedure code on this line	96	M86
t57	The date of service is past timely filing guidelines.	29	
t58	The units of service billed for the procedure code exceed the allowed number of units.	50	N362
t59	Per NCCI edits, the a history procedure has an unbundle relationship with the procedure code	97	M80
t60	Per NCCI edits, the procedure code has an unbundle relationship with a code in history	97	M80

t63	The procedure code has an unbundle relationship with a history procedure code.	97	M80
t64	A history procedure code has an unbundle relationship with the code on the current line	97	M80
t65	The frequency of the procedure code has exceeded the allowable maximum frequency for this code	119	N435
t66	Procedure is identified as an ambulance code and requires an ambulance modifier	4	
t67	The presence of modifier GZ indicates this is not eligible for payment.	96	N30
t68	Procedure indicate multiple imaging services were performed. Per CMS, a 25% reduction of the professional component applies.	59	
t69	Procedure indicate that multiple imaging services were performed. Per CMS, a 25% reduction of the professional component applies to history.	59	
t70	A multiple procedure reduction should be applied to this claim line	59	
t71	Based on this claim line, a multiple procedure reduction should be applied to history	59	
u87	The unit threshold for this procedure has been exceeded.	151	N362
u88	The maximum allowable of units has been exceeded.	151	N362
u89	This procedure is not allowed for reimbursement.	16	N56
u90	This procedure is not appropriate for this patient's gender.	7	
u91	There were multiple procedures that were billed during this time period that exceed the maximum allowed.	119	N362
u92	This medical condition does not justify the procedure performed.	11	N657
u93	This service is not allowed in addition to the other service billed on the same date.	231	
u94	This procedure is not covered when performed in this place of service.	58	
u95	There were multiple procedures that were billed on the same day that exceed the allowed time period.	119	N362
u96	There was not sufficient time between these procedures so this service is not allowed.	119	N362
u97	This procedure is only allowed once per lifetime for this plan.	119	N362
u98	This procedure is not appropriate for the patient's age.	6	N129
u99	This claim requires configuration review.	133	
w01	Invalid diagnosis code unnecessary 4th/5th digit for patient's admission on/discharge date.	146	M76
w02	Invalid diagnosis code missing 4th/5th digit for patient's admission/ discharge date.	146	M76

w03	Invalid procedure code. Not found on table of valid ICD-CM codes.	16	M51
w04	Invalid Procedure code. Unnecessary 4th digit.	16	M51
w05	Invalid Procedure code. Missing 4th digit.	16	M51
w06	Invalid Procedure code. Found on ICD-CM table but not valid for patient's admission/discharge date.	16	M51
w07	Invalid Procedure code. Unnecessary 4th digit for patient's admission/ discharge date.	16	M51
w08	Invalid Procedure code. Missing 4th digit for patient's admission/ discharge date.	16	M51
w09	This claim lacks required HCPCS Level II code for radiopharmaceutical drug.	16	M20
w15	Only whole blood revenue codes can be used when billing for whole blood.	16	M50
w16	This HCPCS code is not approved for a partial hospitalization claim.	16	M51
w17	This HCPCS code can only be billed on a partial hospitalization claim.	16	M51
w18	The charge on this line exceeds the token charge $1.01.	16	M54
w19	This service was provided after the end date of coverage for the National Coverage Determination Policy.	96	N386
w20	This service is denied per Medically Unlikely Edits, the units billed exceed the allowable units for this code.	96	N362
w21	Per LCD or NCD, the patient's age does not meet policy requirements for the procedure code and/or diagnosis code.	6	N115
w22	Per LCD or NCD guidelines, at CTP/HCPCS code is needed to meet policy requirements.	96	N115
w23	Per LCD or NCD guidelines, procedure code has a denied relationship.	96	N115
w24	Per LCD or NCD, the frequency does not meet policy requirements for the procedure code.	96	N115
w25	Per LCD or NCD, the patient's gender does not meet policy requirements for the procedure code and/or a diagnosis code.	7	N115
w26	Per LCD or NCD guidelines, a diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.	96	N115
w27	Per LCD or NCD guidelines, a modifier, which meets medical necessity for the procedure code is missing or invalid.	96	N115
w28	Per LCD or NCD, the condition code is missing or does not meet policy requirements for the procedure code.	96	N115
w29	Per LCD or NCD guidelines, a primary diagnosis code, which meets medical necessity for the procedure code is missing or invalid.	96	N115
w30	Per LCD or NCD guidelines, procedure code has a profiled relationship. Please review the policy.	96	N115
w31	Per LCD or NCD guidelines, documentation should be requested or reviewed for the procedure code	96	N115

w32	Per LCD or NCD guidelines, a secondary diagnosis code, to meet medical necessity for the procedure code, is missing or invalid.	96	N115
w33	Per LCD or NCD guidelines, a tertiary diagnosis code, to meet medical necessity for the procedure code is missing or invalid.	96	N115
w34	Per LCD or NCD, the revenue code does not meet policy requirements for the procedure code.	96	N115
w35	Per LCD or NCD, the type of bill does not meet policy requirements for the procedure code.	96	N115
w36	Per LDC or NCD, the value code is missing or does not meet policy requirements for the procedure code.	96	N115
w37	Per Medically Unlikely Edits, the units of service billed for the procedure code exceed the allowed units	50	N362
w38	Per NCCI edits, a history procedure has an unbundle relationship with the procedure code on this line	97	M80
w39	Per NCCI edits, the procedure code has an unbundle relationship with one in history	97	M80
w40	The Statement Covers Period Through Date of Service is past the facility timely filing limit.	29	
w41	An ICD-9 Diagnosis code in history was compared to an ICD-10 diagnosis code on the current claim.	96	N569
w42	The HCPCS add-on code is lacking a required primary code on the claim.	234	N122
w43	Procedure code must be submitted with required device or procedure code on the same date of service.	16	M20
w44	Review the conditional or independent bilateral procedure code for possible payment adjustment	59	N644
w45	Procedure code is retained from the transfer relationship	P14	
w46	History procedure code is retained from the transfer relationship	P14	
w47	The units have exceeded the allowable maximum frequency per time span	119	N640
w48	The units including history have exceeded the allowable maximum frequency per time span.	119	N640
w49	The units have exceeded the allowable maximum frequency per time span	119	N640
w50	The units have exceeded the allowable maximum frequency per time span	119	N640
w51	Multiple procedures billed for the same Service Date in which a reduction is applicable, per CMS guidelines.	59	N644
w52	Procedure Code should be denied due to a rebundle into another code.	97	M80
w53	History procedure should be denied due to a rebundle into another code.	97	M80
w54	The surgical procedure code contains a termination modifier, and all other services on this claim should be denied based on CMS guidelines.	97	M80
w55	The surgical procedure code contain a terminated modifier and should be reviewed for a 50% reduction.	59	

w56	Bundled codes transfer into new procedure to be added to this claim.	59	
w57	Age and gender conflict; the Admission diagnosis code is not permissible for the patient's age and gender	16	MA65
w58	Age and gender conflict; the Other diagnosis code is not permissible for the patient's age and gender.	16	M64
w59	Age and gender conflict; the Principal diagnosis code is not permissible for the patient's age and gender.	16	MA63
w60	The Admission diagnosis code is invalid because it has an incomplete number of digits.	16	MA65
w61	The Admission diagnosis code is invalid	16	MA65
w62	The Admission diagnosis code is missing	16	MA65
w63	The Other procedure code is invalid based on the Admission date	16	M67
w64	The Other diagnosis code is invalid because it has an incomplete number of digits.	16	M64
w65	The Other procedure code must contain a fourth or fifth digit in order to be valid.	16	M64
w66	The Other diagnosis code must be valid and is effective based on the through date on the claim.	16	M64
w67	The Other procedure code must be in the ICD-PSC code Table.	16	M67
w68	The Other procedure code contains an unnecessary digit.	16	M67
w69	The Principal procedure code must be valid and is effective based on the admission date on the claim.	16	MA66
w70	The Principal diagnosis code does not contain a complete number of digits.	16	MA63
w71	The Principal procedure code must be complete in order to be valid.	16	MA66
w72	The Principal diagnosis code is not valid based on the through date on the claim.	16	MA63
w73	The Principal procedure code must be in the ICD-PSC code Table.	16	MA66
w74	The Principal diagnosis code is missing on the claim	16	MA63
w75	The Principal procedure code contains an unnecessary digit.	16	MA66
w76	The Other diagnosis code is a duplicate of the Principal diagnosis code	16	MA64
w77	The Other diagnosis code is a duplicate of another Other diagnosis code on the claim.	16	M64
w78	Age conflict; the Admission diagnosis is not permissible for the patient's age.	9	
w79	Age conflict; the Other diagnoses is not permissible for the patient's age.	9	

w80	Age conflict; the Principal diagnosis is not permissible for the patient's age.	9	
w81	Gender conflict; the patient's gender and Admission diagnosis code, on the claim are not permissible.	10	N657
w82	Gender conflict; the patient's gender and other diagnosis code, on the claim are not permissible.	10	N657
w83	Gender conflict; the patient's gender and Other procedure code on the claim are not permissible.	7	
w84	Gender conflict; the patient's gender and Principal diagnosis code, on the claim are not permissible.	10	N657
w85	Gender conflict; the patient's gender and Principal procedure code, on the claim are not permissible.	7	
w86	Manifestation codes cannot be used as the Admission diagnosis.	16	MA65
w87	Manifestation codes cannot be used as the Principal diagnosis.	16	MA63
w88	Principal diagnosis code indicates a questionable admission.	16	MA63
w89	Diagnosis code is unacceptable as a principal diagnosis unless a required secondary diagnosis is included on the claim.	16	MA63
w90	Diagnosis code is unacceptable as a principal diagnosis.	16	MA63
w91	An E-code cannot be used as the Admission diagnosis code.	16	MA65
w92	An E-code cannot be used as the Principal diagnosis code.	16	MA63
w93	A non-covered over age 65 ICD procedure code is on the claim and the patient is older than 60 years of age.	6	N129
w94	Procedure code is non-covered when a designated diagnosis code is present.	11	
w95	Procedure code is non-covered unless the exemption ICD Procedure code or exemption ICD Diagnosis code is present.	96	N30
w96	Claim contains procedure codes that may be bilateral procedures: The documentation for procedures, should be reviewed.	16	N657
w97	Age invalid. Must be in range 0-124 years.	16	N329
w98	The patient gender is missing.	16	MA39
w99	The Patient Gender is invalid. Gender must be M, F, or U.	16	MA39
x07	This edit indicates that services essential to a procedure should not be separately coded.	234	M15
x08	This edit indicates that services essential to a procedure should not be separately coded.	234	M80
x09	This procedure is considered part of a more comprehensive procedure. The provider should submit the proper code.	234	M15
x10	This procedure is considered part of a more comprehensive procedure. The provider should submit the proper code.	234	M80

x11	This procedure is considered part of a more comprehensive procedure for this site. The provider should submit the proper code.	B15	M51
x12	This procedure is considered part of a more comprehensive procedure for this site. The provider should submit the proper code.	B15	M80
x13	This edit indicates that with and without codes should not be used together.	50	M51
x14	This edit indicates that with and without codes should not be used together.	B15	M80
x15	This edit indicates that anesthesia should not be reported separately when administered by the operating physician.	194	M80
x16	This edit indicates that anesthesia should not be reported separately when administered by the operating physician.	194	
x17	This edit indicates that individual lab tests should not be reported separately when a lab panel exists.	97	M15
x18	This edit indicates that individual lab tests should not be reported separately when a lab panel exists.	97	M15
x19	This edit indicates that only the code for the more invasive service should be reported.	50	M51
x20	This edit indicates that only the code for the more invasive service should be reported.	50	M51
x21	Preparation or monitor services that are integral to performance of the procedure should not be coded in addition to the procedure.	234	N390
x22	Preparation or monitor services that are integral to performance of the procedure should not be coded in addition to the procedure.	234	M15
x23	These codes should not be reported together per Current Procedural Terminology coding guidelines.	16	M81
x24	These codes should not be reported together per Current Procedural Terminology coding guidelines.	16	M81
x25	These codes should not be reported together per Current Procedural Terminology coding guidelines.	16	M81
x26	These codes should not be reported together per Current Procedural Terminology coding guidelines.	16	M81
x27	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
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	
x90	This edit occurred because the admitting diagnosis code is invalid.	16	MA65
x91	This edit occurred because the admitting diagnosis code is invalid It contains an unnecessary 4th or 5th digit.	16	MA65
x92	This edit occurred because the admitting diagnosis code is invalid. It has a missing 4th or 5th digit.	16	MA65
x93	Invalid patient admission date DX the patient admission date.	146	MA65
x94	Invalid DOA DX, 4th/5th digit date of admission. It contains an unnecessary 4th or 5th digit.	146	MA65
x95	Invalid DOA DX missing digit 4,5 date of admission. It has a missing 4th or 5th digit.	146	MA65
x96	This edit occurred because an invalid diagnosis code cannot be found on table of valid ICD-10-CM codes.	16	M76
x97	This edit occurred because the diagnosis code is invalid. It has an unnecessary 4th or 5th digit.	16	M76
x98	This edit occurred because the diagnosis code is invalid. It has a missing 4th or 5th digit.	16	M76
x99	This edit occurred because an invalid diagnosis code was found on ICD-CM table but is not valid for patient admit or discharge date.	146	M76
y01	The account ID field is missing or invalid.	16	N382
y03	The FTD edit validates the Admission and Discharge Dates at the Claim Level.	16	M52

y04	The CCA edit verifies that the condition codes on the claim are valid.	16	M44
y05	The PSC edit identifies claims that are missing or contains an invalid Patient Discharge Status Code.	16	MA43
y07	The TOB edit identifies claims that are missing or contains an invalid Type of Bill.	16	MA30
y08	The VAL edit confirms that the Value Codes on the claim are valid.	16	M49
y09	The ICMf edit validates that the claim contains the required primary diagnosis prior to HSS processing.	16	MA63
y10	The claim has a missing Patient ID. Analysis cannot be performed without a Patient ID.	16	N382
y11	The DOBf edit identifies a claim that has a missing or invalid DOB. Certain edits cannot be performed without the patient DOB.	16	N329
y13	This edit identifies a claim missing a Provider ID. Analysis cannot be performed without a Provider ID.	207	N257
y17	The SOA edit identifies claims that contain an invalid Source of Admission code.	16	MA42
y18	The TOA edit identifies claims that contain an invalid Type of Admission code.	16	MA41
y19	This edit identifies line items that are potentially duplicates when two lines entered on one or more claims are identical.	18	N522
y21	This edit identifies an entire inpatient claim that is a potential duplicate of a previously submitted inpatient claim.	18	N522
y23	This edit occurred because the first listed diagnosis field is blank or any diagnosis code is not valid for service dates on the claim.	146	M76
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
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
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
z08	The place of service code is missing or invalid.	16	M77
z09	The surgical procedure cannot be crosswalked to an anesthesia code without report.	252	M29
z10	This service is not normally performed for members in this age range.	6	N129
z11	This is a deleted or invalid code or modifier for this date of service . The provider should submit the proper code.	181	M20
z12	This is a deleted or invalid code or modifier for this date of service . The provider should submit the proper code.	181	M20
z13	This service is not covered for this member. The provider should submit the proper code or medical documentation.	7	N115
z14	Documentation is required when a modifier 59 is billed with the procedure code.	252	M127
z15	This is a duplicate of previous claim. If corrected billing please resubmit according to billing guidelines.	18	N522
z16	This claim line is being disallowed because the patients date of birth is missing, invalid, or after the date of service.	16	N329
z17	Claim line is being disallowed because number of units doesn't match the date span between the beginning and ending dates of service.	16	N345
z18	This is a duplicate of a previous claim. If corrected billing please resubmit according to billing guidelines.	18	N522
z20	This claim line is being disallowed because an E and M code is within the global period with a same Diagnosis category by same provider.	97	N525

z21	The procedure code on this claim line is retained from a transfer relationship.	97	M15
z22	Claim line is disallowed because a surgical code was submitted w/in the period w/a Dx from same category by the same provider.	97	N525
z23	A history claim line is disallowed because its procedure code is unbundled and is considered exclusive.	97	M80
z24	A history claim line is disallowed because its procedure code is unbundled and is considered unbundled.	97	M80
z25	A history claim line is disallowed because its procedure code is disallowed as part of a rebundle relationship.	97	M80
z26	A procedure code on a history claim line was part of a transfer relationship, but the procedure code was retained.	97	M15
z27	This condition is not normal for this patient age.	9	N657
z28	This service is not covered when performed for the reported diagnosis.	50	M64
z29	This service is not covered when performed for the reported diagnosis.	50	M64
z30	This claim line is being disallowed because there is no primary diagnosis code.	16	MA63
z31	The procedure can be crosswalked to two or more anesthesia codes and review is required to determine the appropriate code.	252	M29
z32	This claim line is being disallowed because diagnosis code requires a fourth and/or fifth digit to provide appropriate specificity.	16	M64
z33	The claim line contains an inappropriate modifier combination.	4	N519
z34	This is an invalid modifier for this date of service. The provider should submit the proper code.	4	N519
z35	This condition is not normal for this patient gender.	16	N657
z36	This procedure requires modifier 26 be billed.	16	N823
z37	Reimbursement for surgical assistant is not allowed on this procedure code.	54	N646
z38	This edit occurred because the Bilateral adjustment does not apply to this procedure code.	59	N644
z39	This is a bundled service. The payment is included in the service to which item or service is incident.	234	M15
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
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	
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