BlueCare and TennCare*Select* Remittance Advice Code Descriptions

The following remittance explanation codes and descriptions reflect those found on **hardcopy (paper)** BlueCare® and TennCare*Select* remittance advices. These same codes and descriptions will also apply to online BlueCare and TennCare*Select* remittance advices, available on 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 BlueCare/TennCare*Select* explanation code. Standardized descriptions for the HIPAA adjustment reason and remark codes can be accessed on the Washington Publishing Company Web site at

Explanation Code *(Used on paper remit)*	**Description**	**Provider Action/Information (NAR=No Action Required)**	**Corresponding HIPAA Adjustment Reason Code** *(Used on ANSI-835 electronic remit)*	**Corresponding HIPAA Remark Code** *(Used on ANSI-835 electronic remit)*
1A	Authorization Pended first attempt to acquire additional information from requesting provider	NAR	16	N29
2A	Authorization Pended Second attempt to acquire additional information from requesting provider	NAR	16	N29
01	THE MEMBER IS INELIGIBLE AT THE TIME OF SERVICE	NAR	26 or 27	
02	SUBROGATION ADJUSTMENT	NAR – This adjustment is due to information received from a third party payer.	A2	N14
03	REFERRAL FOR SERVICE(S) NOT OBTAINED	Contact Pre-Service to obtain a referral: BlueCare - 1-888-423-0131; TennCareSelect - 1-800-711-4104	62	

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04	CONSENT FORM REQUIRED	Resubmit claim with appropriate, completed consent form. The *Sterilization Consent Form* and *Acknowledgement of Hysterectomy Information Form* can be accessed from the Provider page of the BlueCross BlueShield of Tennessee Web site at www.bcbst.com. The *Certification of Medical Necessity for Abortion* form can be found in the *BlueCare Provider Administration Manual*, which is also available on the company Web site at www.bcbst.com. Forms may be duplicated. Detailed information on completing these forms can be viewed in the *BlueCare Provider Administration Manual*, Section XIII, Sterilization, Hysterectomy, Abortion Procedures.	16	N28
05	WORKERS COMPENSATION	NAR	19	
06	INELIGIBLE EXPENSE	NAR	96	
07	THIS CHARGE WAS PROCESSED ON A PREVIOUS CLAIM	NAR - Duplicate claim	18	
08	CHARGE EXCEEDS AMOUNT APPROVED FOR THIS SERVICE	NAR	45	N14

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09	DEDUCTING PREVIOUS OVERPAYMENT	NAR	129	MA67
10	NOT COVERED FOR PATIENT OVER AGE 8	NAR	6	N30
11	PERSONAL ITEMS	NAR	96	
12	COSMETIC PROCEDURE	NAR	50	
13	NEED FINAL DETERMINATION OF MEDICARE ACTION CODES	NAR	133	N23
14	OVER-THE-COUNTER ITEM	NAR	96	
15	CONSENT FORM INCOMPLETE	Resubmit claim with appropriate, completed consent form Detailed information on completing forms for sterilization, hysterectomy and abortion procedures can be viewed in the *BlueCare Provider Administration Manual,* Section XIII. The manual is available on the Provider page of the BlueCross BlueShield of Tennessee Web site at www.bcbst.com.	16	N3
17	MAXIMUM BENEFITS HAVE BEEN ALLOWED	NAR	35	
18	NOT COVERED FOR THIS TOOTH NUMBER/SURFACE	NAR	96	

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19	INELIGIBLE PROVIDER	NAR – Provider is not contracted to render these services.	52	
20	NOT COVERED FOR PATIENT ABOVE AGE 13	NAR	6	N30
21	NON-EMERGENCY FEE	NAR	40	
22	SERVICES NOT MEDICALLY NECESSARY	NAR – This is the result of clinical review or audit.	50	M27
25	OVER MAXIMUM ALLOWANCE FOR ROOM & BOARD	NAR	78	
26	SURGICAL CODES FILED WITH AN ANESTHESIA MODIFIER	NAR	4	
27	PHYSICIAN MUST BILL SEPARATELY	Physician charges were submitted on CMS-1450 (UB-92) claim form. Resubmit physician charges on CMS-1500 (HCFA-1500) claim form or in ANSI-837P professional transaction.	125	N61
28	CHARGE EXCEEDS AMOUNT APPROVED FOR THIS SERVICE	NAR – Limit has been reached on this service.	45	N14
30	NON-MEDICAL EMERGENCY/NO REFERRAL OBTAINED.	referral: BlueCare - 1-888-423-0131; TennCareSelect - 1-800-711-4104	62	
31	REQUESTING ADDITIONAL INFORMATION	Letter will be sent to provider explaining additional information needed to process claim for benefits.	16	N29
32	REQUESTING INFORMATION FOR ABORTION, STERILIZATION, HYSTERECTOMY SERVICES	Provider will need to submit requested information stated in letter send by the ASH department.	16	N29

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35	TO DETERMINE BENEFITS WE NEED A COPY OF MEDICARE SUMMARY NOTICE	Resubmit claim with Medicare explanation of payment.	22	MA04
38	Pay & Chase - Apply Secondary Benefits	NAR	22	N9
39	INVESTIGATIONAL PROCEDURES	NAR	55	
40	PRIMARY TO ABSENT PARENT COVERAGE	NAR – Informational only, does not affect payment.	45	N14
41	DENIED-NEED OTHER INSURANCE EOB - REFER TO TPL REPORT	Resubmit claim with other insurance explanation of payment. A TPL report listing the member's other insurance information is mailed out to providers who have had claims deny with this explanation code.	22	MA04
46	NON-PARTICIPATING PROVIDER	NAR	38	
47	NON-PARTICIPATING PROVIDER	NAR	38	
48	AUTHORIZATION FOR SERVICE(S) NOT OBTAINED	NAR	62	
50	PAYMENT INCLUDES ALL SERVICES FILED ON THIS CLAIM	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	

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56	EXCEEDS TIMELY FILING LIMIT	Resubmit claim with proof of timely filing: Returned paper claims - black and white copy of the claim with error codes listed at the top of the claim that was returned from BlueCare, along with any returned cover form. Electronic claims - EC290R01/R03 report reflecting rejected individual claims; EC730R01 reflecting accepted and rejected individual claims or the EM735R01 submitter and claim level report generated for ANSI claims.	29	
57	PPO PHYSICIAN PENALTY (UTILIZED NON-PAR FACILITY)	NAR	B6	
58	PPO PHYSICIAN PENALTY - ALSO ABOVE REASONABLE AND CUSTOMARY	NAR	B6	
59	BENEFITS PROVIDED AT CONTRACTED RATES	NAR	45	N14
60	REVIEW NOT REQUESTED WITHIN 180 DAYS TIME FRAME.	See the Billing Guidelines in the BlueCare Provider Administration Manual	138	
62	SURGICAL PROCEDURE CODE REQUIRED	See the Billing Guidelines in the BlueCare Provider Administration Manual	125	M51
63	REQUESTING ADDITIONAL INFORMATION	NAR	16	N29

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64	CHARGES EXCEED OSF ALLOWANCE	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14
66	INELIGIBLE PROCEDURE FOR OSF REIMBURSEMENT	See the Billing Guidelines in the BlueCare Provider Administration Manual	125	M51
67	PRE-ADMISSION TESTING WITHIN 72 HOURS	NAR	60	
68	CONTINUATION OF ORIGINAL EPISODE OF CARE	NAR	97	M15
72	THIS CHARGE WAS PROCESSED ON A PREVIOUS CLAIM (CODE REVIEW)	NAR	18	
73	INTERIM BILLING	See the Billing Guidelines in the BlueCare Provider Administration Manual	135	
76	INAPPROPRIATE MODIFIER FOR TYPE OF PROVIDER	Submit corrected bill, if appropriate.	B6	N95
77	GLOBAL PROCEDURE	NAR - Code bundled with another service included on the claim.	97	M15

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78	GLOBAL PROCEDURE - EXCEEDS MAXIMUM ALLOWABLE	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14
79	NOT SEPARATELY BILLABLE - INCLUDED IN GLOBAL CODE	NAR	97	M15
80	PAYMENT BASED ON NUMBER OF REPLACEMENT TEETH NEEDED	NAR	97	
81	PAYMENT REDUCED TO MAXIMUM AMOUNT ALLOWED FOR X-RAYS	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	
82	PAYMENT REDUCED DUE TO NUMBER OF TEETH IN SECTION OF MOUTH	NAR	97	
83	SERVICES PREFORMED ON PREVIOUSLY EXTRACTED TOOTH	NAR	B13	N37
84	PRE-MEDICATION OR RELATIVE ANALGESIA NOT COVERED	NAR	96	
85	VALID CPT4 OR HCPCS CODE REQUIRED	Submit corrected claim with valid procedure code.	125	M51
86	TIME PERIOD NOT ELAPSED	NAR	119	
87	PROCEDURE NOT COVERED, PAYMENT MADE FOR ALTERNATE PROCEDURE	NAR	B13	

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88	CROWNS.ONLAYS, BRIDGES ND DENTURES COVERED ONCE PER 3	NAR	119	
89	SERVICES NOT COVERED FOR THIS TOOTH	NAR	96	
90	PROCEDURE CLASSIFICATION MODIFIED BY OUR DENTAL CONSULTANTS	NAR	A2	
91	NOT COVERED FOR PATIENT AGE 21 OR OVER	NAR	6	N30
92	CROWNS ONLY COVERED WHEN NO OTHER RESTORATION PROCEDURE APPLICABLE	NAR	97	
93	BITEWING X-RAYS CONSIDERED PART OF A COMPLETE MOUTH SERIES	NAR	97	
94	ONLY ONE RESTORATION OF ANY TOOTH SURFACE IS COVERED	NAR	35	
98	AMOUNT CHARGED LESS THAN OSF FEE SCHEDULE	NAR	94	
99	UTILIZATION MANAGEMENT APPEALS PENDING MEDICAL REVIEW	NAR	133	N29
A8	REFERRAL AUTHORIZATION ACCEPTED	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N45
A9	AUTHORIZATION APPROVED - ELECTIVE	NAR – Informational only.	45	N45
AA	AUTHORIZATION APPROVED - EMERGENCY	NAR – Informational only.	45	N45

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AG	PATIENT IS NOT WITHIN THE AGE FOR SERVICE RENDERED	Procedure code/service limited to certain age(s.) Confirm code and submit corrected bill, if appropriate.	6	N30
AI	INFORMATION WAS NOT SUFFICIENT TO RENDER AN AUTHORIZATION DECISION	Contact the BlueCare Provider Service Line at 1-800-468-9736 or the TennCare*Select* Provider Service Line at 1-800-276-1978.	17	
AL	MISALIGNED NEWBORN-DO NOT PAY OUT CLAIM PER RECOVERY DEPARTMENT	NAR – The Provider was paid by another TennCare Managed Care Organization for the newborn services and will not receive additional reimbursement from BlueCare or TennCare*Select* for these services.	129	MA36
AM	FOUR OR MORE CONCURRENT PROCEDURES ARE NOT ELIGIBLE FOR REIMBURSEMENT	NAR	96	
AN	INAPPROPRIATE CODE FOR TYPE OF PROVIDER	ASA codes billed by any professional other than an anesthesiologist or CRNA are considered inappropriate. Submit corrected claim, if appropriate.	8	N95
AP	MED MGMT-AUTHORIZATION APPROVED	NAR – Informational only.	45	N45
AS	ANESTHESIA CLAIMS MUST BE FILED WITH THE APPROPRIATE ASA CODES	Submit corrected bill with appropriate ASA codes.	8	M51
AT	MISSING ADMIT DATE	Resubmit claim with admit date	125	M59
AV	Service limited to once annually	NAR	95	N130

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AW	AWAITING ALTERNATIVE AUTHORIZATION	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	
BG	REFER TO BILLING GUIDELINES	Refer to your provider contract or the *BlueCare Provider Administration Manual*. The provider administration manual is available on the Provider page of www.bcbst.com.	125	M50
BI	CLAIM MUST BE FILED BY PROVIDER WHO ACTUALLY RENDERED SERVICES	NAR	125	N32
BL	SERVICE NOT COVERED FOR BIEX LAB	NAR	96	
BM	AUTH-MEMBER'S AGE NOT VALID FOR PRIMARY DX UNLESS BABY ON MOTHERS ID	Verify member's age and diagnosis code and submit correction to Pre-Service if applicable	9	N30

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BO	SUBMIT SERVICE(S) TO MEMBER'S BHO	Submit claim to the member's appropriate Behavioral Health Organization (Premier or Tennessee Behavioral Health). The BlueCare Automated Information Line at 1-800-543-8607 can be accessed to determine the member's assigned Behavioral Health Organization.	109	
BS	BUNDLED SERVICE-PAYMENT INCLUDED IN SRVC TO WHICH ITEM/SRVC IS INCIDENT	NAR	97	M15
BT	CORRECTED BILLING TIME LIMIT NOT MET	Corrected bill must be submitted within two years of the end of the year the claim was originally filed.	29	
BW	ORIGINAL CHARGES MUST BE FILED-REFER TO CORRECTED BILLING GUIDELINES	Resubmit corrected claim and include all charges filed on the original claim clearly indicting changes. See corrected billing guidelines in Section V., Billing, of the *BlueCare Provider Administration Manual* available on the Provider page of the BlueCross BlueShield of Tennessee Web site at www.bcbst.com.	133	N29

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BX	STATISTICAL ADJUSTMENT-REFER TO ADJUSTMENT EX CODE FOR REASON OF DENIAL	Review the remittance advice for this claim. On the same line as the "BX" explanation code, there will also be an adjustment explanation code. The adjustment explanation code will help explain the denial. The adjustment explanation description can be found in this listing of explanation code descriptions.	A2	
CB	CLAIM COMBINED WITH A RELATED CLAIM AND CONSIDERED AS ONE CONFINEMENT	Provider will need to contact the Provider Audit Department in writing explaining why they disagee with the denial.	A6	
CC	76375 IS NOT ELIGIBLE UNLESS BILLED WITH ADDITIONAL IMAGING PROCEDURE	Refer to CPT® coding guidelines and submit corrected claim, if appropriate.	97	
CI	Case Management pending for additional(deny) information	NAR	17	N29
CJ	THIS CHARGE IS INCIDENTAL TO THE PRIMARY SERVICES BEING PERFORMED	NAR	97	M15

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CP	CAPITATED SERVICE NOTE:Effective with DOS 1/1/05 and after, provider capitation arrangements are no longer in effect.	NAR	24	
DD	SUBMIT SERVICE(S) TO DORAL DENTAL FOR PROCESSING	If you have any questions or need additional information, contact Doral Dental USA Customer Service at 1-888-554-5542.	109	
DF	DEA NUMBER OR PRESCRIBER ID IS MISSING OR INVALID	NAR	16	
DH	BUNDLED SERVICE-PAYMENT INCLUDED IN SRVC TO WHICH ITEM/SRVC IS INCIDENT	NAR	97	M15
DI	DIAGNOSIS CODE MUST BE FILED TO THE HIGHEST LEVEL OF CLASSIFICATION	Diagnosis on claim was not carried out to the level of specificity (4 or 5 digits) defined in the ICD-9 coding manual. Submit corrected bill with appropriate diagnosis code per the ICD-9 coding manual.	B22	M81
DL	DELETED CODE - CURRENT CPT OR HCPCS CODE REQUIRED FOR DATE OF SERVICE	Submit corrected bill with valid procedure code for date of service.	B18	
DO	PER REVIEW OF CLAIMS-ADJUSTRMENT MADE FOR DEDUCTIBLE OVERPAYMENT	NAR	129	MA67
DR	UNCLASSIFIED DRUG REQUIRES NAME OF DRUG, NDC, QUANTITY AND STRENGTH	Submit claim with name of drug, NDC, quantity and strength noted on the claim.	B17	

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DU	MISSING DAYS OR UNITS	Submit corrected claim with appropriate days or units.	125	M53
DY	MED MGMT-AUTHORIZATION DENIED	Contact the BlueCare Provider Service Line at 1-800-468-9736 or the TennCare*Select* Provider Service Line at 1-800-276-1978.	39	
DZ	SUBMIT CLAIM TO THE STATE'S PBM	Submit claim to First Health Services Corporation, the Bureau of TennCare's Pharmacy Benefits Manager. See *BlueCare Provider Administration Manual*, Section V. Billing Procedures, for Pharmacy Benefits Manager (PBM) Program information, which is available on the BlueCross BlueShield of Tennessee Web site at www.bcbst.com.	109	N95
EA	EXCEEDS THE MAXIMUM ALLOWABLE WITHIN THE SPECIFIED TIME FRAME	NAR	119	
EN	THIS SERVICE REQUIRES MANUFACTURER'S/SUPPLIER'S INVOICE	Resubmit claim with copy of manufacturer's invoice attached to the back of the claim.	133	M23
EO	EMER ROOM CHARGE COMBINED WITH OBSERVATION ROOM WHEN BILLED TOGETHER	NAR	97	M15

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EQ	THE MAXIMUM AMOUNT ALLOWABLE FOR THIS EQUIPMENT HAS BEEN REACHED	Contact the BlueCare Provider Service Line at 1-800-468-9736 or the TennCare*Select* Provider Service Line at 1-800-276-1978, if the service was Medically Necessary.	45	N14
ES	EXCLUDED SERVICE	NAR	96	N130
EX DJ	Due to Deficit Reduction Act (DRA) paying State Medicaid rates	NAR		
EX DK	Due to DRA Emergency Room Clms Reimbursed at 16% of Medicare	NAR		
EX-V2	One or more administration not covered-number of administration codes must match number of injection codes	Multiple units filed on administration code do not match the number of immunization codes filed on the claim. Payment will only be paid on the eligible units. A corrected bill will	57	M53
FF	PRIOR AUTH INDICATES PATIENT TRANSFERRED - VERIFY DISCHARGE STATUS CODE	Submit corrected claim with appropriate discharge status code in form locator 21 of the CMS-1450 (UB-92) claim form or its electronic claims equivalent.	A6	N50
FL	CLAIM MUST BE SUBMITTED THROUGH LOCAL BC/BS PLAN	Submit claim through your local BlueCross BlueShield Plan.	109	
FP	PROCEDURES TO TREAT INFERTILITY ARE INELIGIBLE FOR BENEFITS	NAR	96	

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FT	MISSING FROM AND THROUGH DATE	Submit corrected claim with from and through dates of service	125	M52
G1	AWAITING MEDICAL RECORD - AUTHORIXATION PENDING	Submit medical records to the Pre-Service Area	16	N29
G2	MEDICAL RECORD NOT SUBMITTED	Submit medical records to the Pre-Service Area	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	M127
G3	MEDICAL NECESSITY NOT DETERMINED	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N170
G4	GRIER-MEDICAL RECORD REVIEW-APPROVED	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14
G5	GRIER -PARTIAL-AWAITING MEDICAL RECORD-AUTHORIZATION EXTENSION PENDING	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14

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GA	GRIER APPROVAL-23-HOUR OBSERVATION MORE APPROPRIATE	NAR	45	
GB	GRIER APPROVAL-MEDICAL SERVICES NOT INDICATED AND/OR INAPPROPRIATE	NAR	45	N14
GC	GRIER APPROVAL-SKILLED NURSING VISIT(S) MORE APPROPRIATE	NAR	58	
GD	GRIER APPROVAL- HOME- INFUSION THERAPY MORE APPROPRIATE	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14
GF	GRIER APPROVAL-SKILLED NURSING FACILITY MORE APPROPRIATE	NAR	45	
GG	GRIER APPROVAL-SUB-ACUTE LEVEL OF CARE MORE APPROPRIATE	NAR	45	
GH	GRIER APPROVAL-PROCEDURE MORE APPROPRIATE FOR OUTPATIENT	NAR	45	
GI	GRIER APPROVAL-A MORE CONSERVATIVE TREATMENT WOULD BE APPROPRIATE	NAR	45	N14
GJ	GRIER APPROVAL-THERAPY (THERAPIES) MORE APPROPRIATE FOR THE OUTPATIENT	NAR	45	

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GK	GRIER APPROVAL-THERAPY (THERAPIES) MORE APPROPRIATE IN THE HOME SETTING	NAR	45	
GL	GRIER APPROVAL-NUMBER OF MEDICAL SERVICES REQ. NOT MEDICALLY APPROPRIATE	NAR	45	N14
GM	GRIER APPROVAL-HOSPICE SETTING MORE APPROPRIATE	NAR	45	
GN	GRIER APPROVAL-TRANSITIONAL PERIOD OF PRIVATE DUTY NURSING MORE APPROPRIATE	NAR	45	
GO	GRIER APPROVAL-REQ. SERVICES MORE APPROPRIATE FOR A PHYSICIAN'S OFFICE	NAR	45	
GP	GRIER APPROVAL-INFORMATION RECEIVED NOT SUFFICIENT TO RENDER A DECISION	NAR	45	N14
GS	GRIER APPROVAL-STANDARD EQUIP. MEETS THE MEDICAL NEEDS OF THE MEMBER	NAR	45	N14
GV	OUT OF NETWORK APPROVAL REQUIRED	NAR	38	
H1	PROVIDER IS NOT CONTRACTED TO RENDER THESE SERVICES	NAR – Used to indicate Home Health, Home Infusion Therapy and/or Durable Medical Equipment provider does not participate in the BlueCare Network.	38	

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HC	RETROSPECTIVE REVIEW WILL BE COMPLETED	A letter will be sent to the provider requesting information for a retrospective review. Submit requested information upon receipt of the letter.	45	N14
HD	NDC REQUIRED ON HIT DRUGS	Resubmit claim with 11-digit National Drug Code (NDC). For electronic claims submitted in the ANSI-837, version 4010A1 format, include the NDC number in the Loop 2410 LIN03 segment with the N4 qualifier in LIN02. The NDC number should be right justified and zero-filled to meet the 11-digit requirement. For paper claims, include the NDC number in Block 24D of the CMS-1500 claim form.	16	M119
HI	NEED DETAILED ITEMIZATION FOR SERVICES RENDERED	Submit claim with itemization of services provided.	133	N26
IA	INCOMPLETE/INVALID REFERRAL	Submit claim with correct referral to the Pre- Service Area	62	
IM	INCORRECT PCM	NAR	52	
IP	PER DIEM PAYMENT MADE TO FACILITY INCLUDES CHARGES FOR THIS CONFINEMENT	NAR	97	M15

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JC	PRESCRIPTION DRUG CHARGES SHOULD BE FILED THROUGH THE PHARMACY SYSTEM	Submit claim to First Health Services Corporation, the Bureau of TennCare's Pharmacy Benefits Manager. See *BlueCare Provider Administration Manual*, Section V. Billing Procedures, for Pharmacy Benefits Manager (PBM) Program information, which is available on the BlueCross BlueShield of Tennessee Web site at www.bcbst.com.	109	
JM	Correction to Prior Claim, Refer to adjusted claim for correct adjudication.	NAR	63	MA67
JP	CORRESPONDENCE TO FOLLOW	NAR (Review correspondence)	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14
JQ	CORRESPONDENCE TO FOLLOW	NAR (Review correspondence)	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14

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JR	CORRESPONDENCE TO FOLLOW	NAR (Review correspondence)	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14
KB	CHARGE EXCEEDS AMOUNT APPROVED FOR THIS SERVICE.	NAR – This code triggers a letter to the Primary Care Practitioner to inform the PCP the member was seen in the emergency room.	45	N14
KL	THIS SERVICE IS INELIGIBLE WHEN BILLED WITH MEDICAL SCREENING	NAR – These ancillary services not eligible for reimbursement when billed with a triage visit.	97	
KR	NON-EMERGENCY FEE	NAR – Emergency room or triage visit was for non-emergency condition.	40	
L0	Medicare Part A exhausted, please submit Medicare Part B MSN	NAR	22	MA04
L1	PATIENT NAME ON CLAIM DOES NOT MATCH EXPLANATION OF BENEFITS.	Confirm patient name on claim and explanation of benefits (EOB). Submit claim and corresponding EOB.	22	N48
L2	DATE OF SERVICE ON CLAIM DOES NOT MATCH EXPLANATION OF BENEFITS	Confirm date of service on claim. Submit claim with corresponding explanation of benefits.	22	N48

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L3	PROCEDURE CODE(S) ON CLAIM DOES NOT MATCH EXPLANATION OF BENEFITS	Confirm procedure codes on claim. Submit claim with corresponding explanation of benefits.	22	N48
L4	CHARGED AMOUNT ON CLAIM DOES NOT MATCH EXPLANATION OF BENEFITS	Confirm charges on claim. Submit claim with corresponding explanation of benefits.	22	N48
L5	AN EXPLANATION OF OTHER INSURANCE NON-COVERED CHARGE(S) IS REQUIRED	Submit claim with explanation of other insurance non-covered charges.	22	N48
L6	THE EXPLANATION OF BENEFITS ATTACHMENT WAS INCOMPLETE	Submit claim with complete explanation of benefits.	22	N48
L7	ORIGINAL EOB FROM THE OTHER INSURANCE CARRIER IS REQUIRED	Submit claim with other insurance explanation of benefits.	125	MA04
L8	RESUBMIT CLAIM AFTER OTHER INSURANCE FINAL BENEFIT DETERMINATION	Submit claim with other insurance explanation of benefits showing final benefit determination.	22	MA04
L9	RUN DATE ON OTHER INSURANCE EXPLANATION OF BENEFITS IS REQUIRED	Submit claim with complete explanation of benefits showing other insurance run date.	22	N48
LA	MEMBER IS STILL EFFECTIVE WITH PRIMARY INSURANCE - NEED CORRECTED EOB	Submit claim to other, primary insurance carrier. Claim and corrected explanation of benefits can then be resubmitted to BlueCare.	22	N48

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LB	INCORRECT POLICY# FILED WITH PRIMARY INSURANCE - NEED CORRECTED EOB	Submit claim to other, primary insurance carrier with correct policy number. Claim and corrected explanation of benefits can then be resubmitted to BlueCare.	22	N48
LC	THIS SERVICE IS NOT ELIGIBLE FOR THIS DIAGNOSIS OR LOCATION	Confirm diagnosis/location and submit corrected claim, if appropriate.	5	
LD	PER PRIMARY CARRIER EOB/PAYMENT IS INCORRECT, NEED CORRECTED EOB	Resubmit claim with corrected EOB from primary carrier.	22	N48
LE	EXCEEDS LIMIT OF 1 EVERY 30 DAYS	Refer to CPT® guidelines regarding Care Plan Oversight Services.	119	
LI	SERVICES INCLUDED IN THE OSF/DRG RATE OR SHOULD HAVE SENT TO LAB ONE	The LabOne exclusion list of lab tests that may be performed by BlueCare and TennCare*Select* providers is available on the Provider page of the BlueCross BlueShield of Tennessee Web site at www.bcbst.com. Tests not included on the exclusion list must be performed by LabOne.	109	N95

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LO	SERVICES SHOULD BE SENT TO LABONE	The LabOne exclusion list of lab tests that may be performed by BlueCare and TennCare*Select* providers is available on the Provider page of the BlueCross BlueShield of Tennessee Web site at www.bcbst.com. Tests not included on the exclusion list must be performed by LabOne.	109	N95
LP	MUST BE REPORTED IN ADDITION TO THE VACCINE AND TOXOID CODES 90476-90749	Administration fee is only reimbursed when a corresponding vaccine/toxoid code is also billed. Submit corrected claim, if appropriate.	125	M51
LT	MAXIMUM ALLOWABLE BENEFITS HAVE BEEN PROVIDED	NAR	35	N14
LW	TPL ADJUSTMENTS	NAR	22	MA67
M6	MEMBER SPAN CROSSES MEMBER CLASS - SPLIT CLAIM	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14

BlueCare and TennCare*Select* Remittance Advice Code Descriptions

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MB	INAPPROPRIATE MODIFIER FOR TYPE OF SERVICE	Review claim and submit corrected bill, if appropriate. The AA, AD, QK, QX, QY, or QZ modifiers should be used with valid ASA codes.	4	
MC	SERVICE COVERED UNDER MEMBER'S PCM CAPITATION ARRANGEMENT	NAR	24	
MI	INVALID CODE/MODIFIER	Submit corrected bill, if appropriate.	B18	
MM	MEMBER ON REVIEW BY CASE MANAGEMENT	NAR – Informational only. Payment not affected.		
MO	PROCEDURE CODE/MODIFIER CONFLICT-PLEASE CORRECT AND REFILE	Review code/modifier and submit corrected claim, if appropriate.	4	
MP	PROVIDER SHOULD BILL MEDICARE AS PRIMARY CARRIER	Submit claim to Medicare for reimbursement then refile claim with EOB attached to the claim	22	MA04
MS	MEMBER IS DUAL ELIGIBLE, BILL CONSULTEC	NAR	109	N36
MT	MEDICAL CHART NOT SENT WITHIN TIME FRAME REQUIRED FOR REVIEW.	Provider will need to contact the Provider Audit Department in writing explaining why they disagee with the denial.	138	

BlueCare and TennCare*Select* Remittance Advice Code Descriptions

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MX	CLAIM PROCESSED FOR PAYMENT	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14
MZ	FILLED AFTER PRESCRIPTION EXPIRATION DATE	NAR	96	
N1	First attempt for additional info for a predetermination		16	N29
N2	Second attempt for additional info for a predetermination		16	N29
NA	AUTHORIZATION REQUIRED, FUTURE CLAIMS WILL BE DENIED IF NOT OBTAINED	Contact the Pre-Service Area to obtain an authorization	15	
NB	SERVICES NOT BILLABLE ON A HCFA 1500 CLAIM FORM	Resubmit claim on a CMS-1450 claim form or ANSI-837I institutional electronic format.	125	N34
NC	DENIED DUE TO NONCOMPLIANCE WITH PRIMARY INSURER'S CONTRACT PROVISIONS	BlueCare will not reimburse services where provider did not follow primary insurer's contract rules (i.e, authorization not obtained, claim not filed timely, etc.) and claim was denied.	136	N23

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ND	SERVICES RENDERED FOR THIS DIAGNOSIS NOT COVERED PER MEMBERS CONTRACT	NAR	47	
NE	REFERRAL FOR SERVICE (S) NOT OBTAINED	Contact Pre-Service to obtain a referral: BlueCare - 1-888-423-0131; TennCareSelect - 1-800-711-4104	62	
NF	CLAIMS FOR SKILLED NURSING FACILITY SHOULD BE BILLED THROUGH THE STATE	Submit skilled nursing facility claim to Bureau of TennCare.	109	N36
NM	PAYMENT WITHHELD PER RECEIPT OF MEDICAID NUMBER	BlueCare providers should apply for a Medicaid provider number with the State Medicaid office. Payments will continue to be held until BlueCross BlueShield of Tennessee has record of the Medicaid provider number. A copy of the letter from the State assigning the Medicaid number should be sent to the provider's local BlueCross BlueShield of Tennessee Provider Relations representative. Following receipt of the information, the Medicaid number will be loaded into BlueCross BlueShield of Tennessee systems and any held payments will be released.	17	

BlueCare and TennCare*Select* Remittance Advice Code Descriptions

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NN	NON-COMPLIANT WITH PRE-AUTHORIZATION GUIDELINES	NAR	15	
NP	NON-PHYSICIAN ASST AT SURGERY SVCS INCLUDED IN PHYSICIAN/FACILITY PMT	NAR	8	M97
NR	DENIED DUE TO MEDICAL RECORDS NOT RECEIVED	Department. Note: ASH Department will send a letter to the provider explaining what information is needed.	133	M127
NS	INFORMATION GIVEN ON AUTHORIZATION NOT SUPPORTED IN RECORDS RECEIVED	NAR	15	
NT	PAYMENT FOR SERVICES REIMBURSED UNDER NTN GLOBAL PAYMENT	NAR	97	M15
NV	VOLUNTEERS NOT USED. PLEASE FILE THE APPROPRIATE MILEAGE OR HCPCS CODE.	NAR – Non-emergency transportation provided by a volunteer is not a covered service. Resubmit corrected bill, if appropriate.	125	
OA	APPROVED ORDERS FOR INPATIENT STAY NOT INCLUDED IN MEDICAL RECORDS	Provider will need to contact the Provider Audit Department in writing explaining why they disagee with the denial.	62	
OE	OUT OF STATE NON-PARTICIPATING PROVIDER	Contact the Pre-Service Area to obtain an authorization	38	N256

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P0	FOR DOS FILED, PROVIDER NUMBER IS INELIGIBLE FOR BENEFITS	Contact your local Provider Relations representative if you feel the provider number should have been active for the dates of service indicated on the claim.	B7	
P1	PROCEDURE CODE WAS REPLACED BASED ON DESCRIPTION SUBMITTED ON CLAIM	NAR	97	N22
P2	REPLACEMENT PROCEDURE CODE-EXCEEDS MAXIMUM ALLOWABLE	NAR – Indicates the code that was replaced based on the description submitted on the claim.	65	N22
P3	VERIFY ANESTHESIA TIME - RESUBMIT AS CORRECTED BILL	Submit corrected bill with appropriate anesthesia time.	125	M125
P4	PROVIDE DOS FOR EACH CHARGE FOR THERAPY - RESUBMIT AS CORRECTED BILL	Submit corrected bill showing date of service for each therapy charge on the claim.	125	N26
P5	VERIFY IF CHARGES ARE FOR MOM OR BABY - RESUBMIT AS CORRECTED BILL	Resubmit claim as corrected bill after verifying the charges are for mom or baby	125	N15
P6	PROVIDE A DME MODIFIER OF P OR R - RESUBMIT AS CORRECTED BILL	Resubmit claim as corrected bill with DME modifier NU or RR	4	M78
P7	PROVIDE TRANSPORTATION MODIFIER - RESUBMIT AS CORRECTED BILL	Submit corrected bill with valid modifier. A valid two-character, alpha modifier is required on all emergency and non-emergency transportation claims.	4	M78
P8	INDICATE WHICH TWIN RECEIVED SERVICES - RESUBMIT AS CORRECTED	Submit corrected bill indicating which twin received services.	125	MA36
P9	Payment withheld for receipt of GRP provider par documentation (Deny)	NAR	17	N358

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PG	CHARGES ARE COMBINED WITH INPATIENT CLAIM OF AFFILIATED HOSPITAL	A letter will follow with further information. This is due to outpatient services being rendered at a hospital affiliated with a hospital where inpatient services were also rendered. Outpatient charges are combined with DRG charges.	B20	
PH	PHYSICIAN/SURGICAL ASSISTANT NOT ELIGIBLE TO PERFORM SERVICE	No Action Required - Reimbursement for assistant-at-surgery services provided by non-physicians is included in the reimbursement to the licensed practitioner for services provided in the physician's office or in thereimbursement to the facility for services provided in an inpatient or outpatient setting.	B6	
PI	AWAITING MEDICAL RECORD - AUTHORIZATION PENDING	Contact the BlueCare Provider Service Line at 1-800-468-9736 or the TennCare*Select* Provider Service Line at 1-800-276-1978.	17	M127
PJ	THIS CPT/HCPCS CODE IS NOT APPROPRIATE FOR CHARGES RENDERED	A letter will follow with further information. Medical chart does not include sufficient documentation to support the use of the code billed.	125	M51

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PK	THIS CPT CODE IS BEING ADDED DUE TO APPROPRIATENESS	A letter will follow with further information. CPT® code has been added to the claim filed due to chart review.	45	N22
PL	IF NOT THE PATIENT'S CURRENT PCM, FUTURE CLAIMS MAY BE DENIED	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14
PM	PAYMENT BASED ON PER DIEM ALLOWANCE	NAR	A2	N14
PN	EXCEEDS THE MAXIMUM ALLOWABLE NUMBER OF SERVICES WITHIN 14 DAY RANGE	NAR	119	
PP	SERVICES NOT RENDERED WITHIN 14 DAYS OF ENROLLMENT IN PROGRAM	NAR	B5	
PQ	PER AUDIT - CHARGE IS PART OF GLOBAL CPT CODE ON DIFFERENT CLAIM	A letter will follow with further information. This determination resulted from a provider audit.	97	N10
PT	PRE-ADMISSION AND POST-DISCHARGE SERVICES COMBINED WITH INPATIENT CLAIM	A letter will follow with further information. This determination resulted from a provider audit.	60	
PU	CHARGES ARE CONSIDERED AS A PART OF MEMBER'S INPATIENT CONFINEMENT	A letter will follow with further information. This determination resulted from a provider audit.	A2	

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PV	PRE-ADMISSION TESTING CHARGES ARE COMBINED WITH MEMBER'S SURGERY CHARGES	A letter will follow with further information. This determination resulted from a provider audit.	60	
PW	PER MED CHART-A 23-HR ADMIT WAS RENDERED INSTEAD OF AN INPATIENT STAY	A letter will follow with further information. This determination resulted from a provider audit.	125	N10
PX	PER AUDIT-CHARGE IS CONSIDERED GLOBAL OF SIMILAR CPT CODE ON CLAIM	A letter will follow with further information. This determination resulted from a provider audit.	97	N10
PY	PER AUDIT-CHARGE IS A DUPLICATE OF A CPT CODE FILED ON THE SAME CLAIM	A letter will follow with further information. This determination resulted from a provider audit.	B13	N10
PZ	PER AUDIT-CHARGE IS PART OF MEMBER'S GLOBAL MATERNITY REIMBURSEMENT	A letter will follow with further information. This determination resulted from a provider audit.	97	N10
QI	AUTH DENIED, NO RESPONSE RECEIVED TO OUR REQUEST FOR MEDICAL INFO	Submit medical records to Pre-Service Area	15	
R0	REFILL TOO SOON	NAR	119	
R1	GLOBAL PROCEDURE - EXCEEDS MAXIMUM ALLOWANCE	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	

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R2	GLOBAL PROCEDURE	NAR – Claim denied due to other global codes filed on claim (i.e, claim filed with surgery charges and follow-up visits on same claim for same dates of service on the same claim; claim filed for two office visits on the same date of service without a 25 modifier;)	97	M15
R5	GLOBAL PROCEDURE	NAR – Charges replaced by a more global code.	97	M15
R6	GLOBAL PROCEDURE - EXCEEDS MAXIMUM ALLOWABLE	NAR	45	N22
R9	CHARGE EXCEEDS AMOUNT APPROVED FOR THIS SERVICE	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	N14
RB	Invalid modifier / Procedure code	NAR	4	
RD	REIMBURSEMENT FOR ACCESSORY/SUPPLY IS INCLUDED IN RENTAL OF EQUIPMENT	NAR	97	M3
RG	Invalid modifier	NAR	182	

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RI	PROVIDE DESCRIPTION OF CODE	Resubmit claim with the description of code.	125	M51
RJ	REQUESTING ADDITIONAL INFORMATION	NAR	133	N29
RO	CHARGE SHOULD BE FILED WITH CODE J3490. SUBMIT NDC NUMBER AND	Submit corrected claim with J3490, indicating NDC number and units.	125	M119
RP	RADIOPHARMACEUTICAL IMAGING AGENT REQUIRES MANUFACTURER'S INVOICE	Submit claim with manufacturer's invoice listing the name of the patient, date of service, number of units provided and acquisition cost for diagnostic radiopharmaceutical imaging agents.	16	M23
RQ	100% PROSPECTIVE REVIEW REQUIREMENT NOT MET	Contact the Pre-Service Area to obtain an authorization	133	
RR	NO REFERRAL, ADDITIONAL INFORMATION REQUIRED	Contact Pre-Service to obtain a referral: BlueCare - 1-888-423-0131; TennCareSelect - 1-800-711-4104	62	
RS	5% RISK TAKEN ON CHARGES	NAR	42	N14
RT	PAYMENT FOR LESS THAN 3 FRACTIONS IS CONSIDERED IN PAYMENT ALREADY MADE	NAR	97	M15
SA	MISSING SOURCE OF ADMISSION	Submit corrected claim and include source of admission.	125	MA42
SB	RELATED TO WORKERS COMPENSATION PER SUBROGATION DEPARTMENT	Submit claim with Workers Compensation carrier	19	N10

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SC	PROCEDURE NOT COVERED FOR SIGNAL CENTER	NAR	52	
SF	DOES NOT MEET STATE/FEDERAL ASH REQUIREMENTS	NAR – Does not meet state or federal abortion, sterilization or hysterectomy (ASH) requirements.	B5	
SH	RECORDS RECEIVED WERE INCOMPLETE	Requested information was not supplied. A letter from BlueCare Utilization Management outlined required information. Refer to the letter requesting information and submit required records.	17	N29
SI	OPERATIVE REPORT REQUIRED	Submit claim with operative report.	133	M29
SM	SUBMIT MANUFACTURER/SUPPLIER'S INVOICE	Submit claim with manufacturer's invoice.	133	M23
SN	SKILLED NURSING FACILITY CHARGES ARE NOT ELIGIBLE	NAR	109	
SP	SPECIAL REVIEW	should be forwarded to Christina Howser, 3G	133	
SS	PROVIDER NOT ELIGIBLE FOR NETWORK PARTICIPATION	NAR	38	
SX	PATIENTS'S SEX IS NOT VALID FOR SERVICES RENDERED	NAR	7	N30
TB	MISSING OR INVALID TYPE OF BILL	Resubmit claim as corrected bill with correct type of bill.	5	MA30
TC	T.C. THOMPSON BABY CHARGES INCLUDED IN MOTHER'S PERDIEM PAYMENT	NAR	128	N111

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TG	PAYMENT INCLUDED IN TRANSPLANT GLOBAL PAYMENT	NAR	97	M15
TI	ANESTHESIA FLOW SHEET REQUIRED	Submit claim with anesthesia flow sheet.	17	N29
TP	CAPITATED SERVICE	NAR	24	
TR	TRIAGE SERVICE PRIOR TO DATE OF SERVICE 10/01/98.	NAR	96	
TT	POSSIBLE CORRECTED BILL-ADDITIONAL INFO NEEDED-LETTER	Letter of instruction will be mailed from BlueCare regarding this claim.	133	
UF	INVALID NUMBER OF UNITS FOR FROM AND THROUGH DATES	Review from and through dates on claim and submit a corrected bill, if appropriate.	125	M53

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UL	UNLISTED PROCEDURE: SUPPLEMENTAL INFORMATION IS REQUIRED	Supplemental information is needed to correctly reimburse unlisted procedure codes. The information required will be dependent on the type of code/service provided. For example, an operative report should be attached to an unlisted surgery code. Other types of supplemental information include: description of the procedure or service provided; an anesthesia flow sheet for anesthesia procedures; the name of the drug/immune globulin/immunization/vaccine/toxoid, National Drug Code (NDC), dosage, and number of units provided; a manufacturer/supplier's invoice listing the name of the patient, date of service, number of units provided, and acquisition cost for diagnostic radiopharmaceutical imaging agents; documentation of the time and effort necessary to perform procedure or service.	125	M51
UZ	PER AUDIT - RECONSIDERATION ON CLAIM AUDITED WAS UPHELD	NAR	96	MA46

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VA	VA HOSP-CLAIM NEEDS TO BE FILED WITH THE DEPARTMENT OF VETERANS AFFAIRS	Submit claim to the Department of Veterans Affairs.	109	N36
VC	REIMBURSEMENT IS FOR THE ADMINISTRATION ONLY	NAR – Benefits provided under the Vaccines for Children Program and are for handling/administration of the vaccine only.	45	N14
VD	RESUBMIT WITH VALID ADMIT AND DISCHARGE DATE IN BLOCK 18	No additional action necessary.	125	M52
VS	MAXIMUM ALLOWANCE FOR CATARACT BENEFITS	NAR	119	
W1	RECOVERING BENEFITS - ORIGINAL CLAIM PAID TO WRONG PROVIDER	NAR	129	MA67
W2	RECOVERING BENEFITS - ORIGINAL CLAIM PAID UNDER WRONG PATIENT	NAR	129	MA67
W3	RECOVERING BENEFITS OF AN OVERPAID CLAIM	NAR	129	MA67
W4	PROVIDING ADDITIONAL BENEFITS - ORIGINAL CLAIM WAS UNDERPAID	NAR	A2	MA67
W5	RECOVERING BENEFITS OF A DUPLICATE CLAIM PAYMENT	NAR	129	MA67
W6	PAID PRIMARY BENEFITS, SHOULD HAVE PAID SECONDARY	NAR	129	MA67
W7	STATISTICAL ADJUSTMENT	NAR – Adjustment is being made due to a data correction (i.e., account number). Payment is not affected.	45	MA67

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W8	CORRECTED BILLING FROM PROVIDER	NAR	125	MA67
W9	ADJUSTMENT DUE TO CHANGE IN PROVIDER CONTRACT	NAR	129	MA67
WA	ADJUSTMENT MADE FOR COPAY OVERPAYMENT	NAR	129	MA67
WB	MEDICAL RECORDS DO NOT SUPPORT THE BILLED PROCEDURE	NAR	B12	MA67
WC	DENIED-INCORRECT OR INELIGIBLE PROCEDURE CODE	NAR – This determination resulted from a provider audit.	129	M51
WD	RECOVERING BENEFITS-SERVICES RENDERED ARE DUE TO WORKERS COMPENSATION	NAR	129	MA67
WE	RECEIVED ELIGIBILITY UPDATE MEMBER RETRO-TERMED	NAR	27	
WF	REVISION OF BENEFITS-INCORRECT NUMBER OF SERVICES PAID ON ORIGINAL CLAIM	NAR	45	MA67
WG	REVISION OF BENEFITS-INCORRECT DRG/PERDIEM RATE PAID ON ORIGINAL CLAIM	NAR	45	MA67
WH	REVISION OF BENEFITS-ORIGINAL CLAIM PAID WITH INCORRECT OSF ALLOWANCE	NAR	45	MA67
WI	REVISION OF BENEFITS-CLAIM IS PART OF INTERIM BILLING	NAR	45	MA67

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WJ	REVISION OF BENEFITS- ORIGINAL CLAIM CALCULATED AT INCORRECT PERCENTAGE	NAR	45	MA67
WK	STATISTICAL ADJUSTMENT-COLLECTION AGENCY INVOLVED	NAR – Payment is not affected by a statistical adjustment.	45	MA67
WL	REVISION OF BENEFITS - PAYMENT SHOULD HAVE APPLIED TO DEDUCTIBLE	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	MA67
WM	REVISION OF BENEFITS- ORIGINAL CLAIM REFLECTED INCORRECT DATE OF SERVICE	NAR	45	MA67
WN	REVISION OF BENEFITS - ORIGINAL CLAIM REFLECTED INCORRECT CPT/HCPCS CODE	NAR	45	MA67
WO	REVISION OF BENEFITS - REIMBURSED ON SERVICES NOT RENDERED	NAR	45	MA67
WP	REVISION OF BENEFITS-ORIGINAL CLAIM HAD INCORRECT ASSISTANT SURGEON RATE	NAR	45	MA67
WQ	STATISTICAL ADJUSTMENT-COLLECTIONS FOR BLUECARE	NAR – Payment is not affected by a statistical adjustment.	129	MA67

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WR	REVISION OF BENEFITS - ORIGINAL CLAIM PAID INCORRECT AIR AMBULANCE RATE	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	MA67
WS	REVISION OF BENEFITS-ORIGINAL CLM CALCULATED AT INCORRECT CO-INS AMT	NAR	42 Note: If claim has a paid amount of zero, the adjustment reason will be 45 instead of 42.	MA67
WT	PER AUDIT-MEMBER IS NOT A NEW PATIENT	Verify claim information and submit corrected claim.	B16	MA67
WU	SERVICES PROVIDED AFTER MEMBER'S DEATH	NAR	13	
WV	RETURNED BCBST CHECK THAT IS NOW VOIDED	NAR	45	MA74
WX	PER AUDIT - SINGLE LINE BILLED IN ERROR	NAR – This determination resulted from a provider audit.	125	M51
WY	WORKER'S COMP ADJUSTMENT DUE TO 3RD PARTY ENTITY RECOUPMENT	NAR	19	N9
WZ	SUBROGATION ADJUSTMENT DUE TO 3RD PARTY ENTITY RECOUPMENT	NAR	20	N9
XV	THIS SERVICE IS NOT ELIGIBLE FOR THIS DIAGNOSIS	Verify diagnosis code and submit corrected bill if applicable.	B22	

BlueCare and TennCare*Select* Remittance Advice Code Descriptions

Explanation Code *(Used on paper remit)*	Description	Provider Action/Information (NAR=No Action Required)	Corresponding HIPAA Adjustment Reason Code *(Used on ANSI-835 electronic remit)*	Corresponding HIPAA Remark Code *(Used on ANSI-835 electronic remit)*
ZA	RESUBMIT CLAIM WITH ROOM & BOARD AND ALL ANCILLARY CHARGES	Resubmit claim with Room and Board and all ancillary charges	16	N29
ZE	BILLED CHARGES ARE NOT GREATER THAN ZERO	NAR – Negative or zero charges submitted.	45	N14