BlueCross BlueShield of Texas

INELIGIBLE REASON CODE LIST

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
PRE-PAY REVIEW	**AP1**	ADDITIONAL INFORMATION IS REQUESTED FROM THE PROVIDER. IF NO RESPONSE IS RECEIVED WITHIN 45 DAYS OF THIS NOTICE, NO FURTHER NOTICE WILL BE GIVEN, AND BENEFITS WILL BE CONSIDERED DENIED.
PRE-PAY REVIEW	**AP2**	ADDITIONAL INFORMATION IS REQUESTED FROM THE PROVIDER. IF NO RESPONSE IS RECEIVED WITHIN 45 DAYS OF THIS NOTICE, NO FURTHER NOTICE WILL BE GIVEN, AND BENEFITS WILL BE CONSIDERED DENIED.
PRE-PAY REVIEW	**AP3**	SERVICES NOT DOCUMENTED IN PATIENT'S MEDICAL RECORDS. PATIENT SHOULD NOT BE BILLED FOR THE UNDOCUMENTED SERVICES.
PRE-PAY REVIEW	**AP4**	SERVICES NOT DOCUMENTED IN PATIENT'S MEDICAL RECORDS. PATIENT SHOULD NOT BE BILLED FOR THE UNDOCUMENTED SERVICES.
PRE-PAY REVIEW	**AP5**	DRG CODING REVIEW COMPLETED, IT WAS FOUND TO BE TO BE INCONSISTENT WITH THE MEDICAL RECORDS SUBMITTED. THE ALLOWANCE ON THE CLAIM REFLECTS THE DRG FROM DOCUMENTATION.
PRE-PAY REVIEW	**AP6**	DRG CODING REVIEW COMPLETED, IT WAS FOUND TO BE TO BE INCONSISTENT WITH THE MEDICAL RECORDS SUBMITTED. THE ALLOWANCE ON THE CLAIM REFLECTS THE DRG FROM DOCUMENTATION.
AUTHORIZATION ISSUE	**110**	STAY EXCEEDS NUMBER OF DAYS PRE-CERTIFIED. ADDITIONAL DAYS NOT MEDICALLY NECESSARY.
AUTHORIZATION ISSUE	**216**	GROUP RECERTIFICATION REQUIRED FOR THIS BENEFIT.
AUTHORIZATION ISSUE	**217**	RECERTIFICATION FOR EACH CONFINEMENT/SERVICE WAS NOT DONE.
AUTHORIZATION ISSUE	**338**	BENEFITS FOR SERVICES WERE NOT APPROVED DURING THE PRE-CERT PROCESS.
AUTHORIZATION ISSUE	**339**	SERVICES WERE NOT PRE-CERTIFIED.

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AUTHORIZATION ISSUE	**347**	MEDICAL/SURGICAL ADVISOR CONTACTED BUT DID NOT APPROVE THE SERVICES / TREATMENT.
AUTHORIZATION ISSUE	**364**	MEDICAL DEPARTMENT APPROVED FACILITY, BUT NOT ACTUAL ORGAN TRANSPLANT.
AUTHORIZATION ISSUE	**366**	MEDICAL DEPARTMENT HAS NOT APPROVED THE FACILITY OR THE ORGAN TRANSPLANT.
AUTHORIZATION ISSUE	**374**	ECF MUST BE RECERTIFIED EVERY 30 DAYS.
AUTHORIZATION ISSUE	**509**	MEDICAL GROUP DID NOT APPROVE SERVICES.
AUTHORIZATION ISSUE	**510**	MEDICAL GROUP DID NOT APPROVE.
AUTHORIZATION ISSUE	**511**	LATE DISCHARGE NOT AUTHORIZED.
AUTHORIZATION ISSUE	**529**	PRE-ADMISSION REVIEW: REVIEW OBTAINED, HOWEVER PORTIONS OF THE STAY NOT APPROVED BY ADVISOR.
AUTHORIZATION ISSUE	**561**	ADVISOR CONTACTED; HOWEVER, PORTION OF STAY EXCEEDS LENGTH APPROVED.
AUTHORIZATION ISSUE	**562**	ADVISOR NOT CONTACTED AND PORTION OF STAY EXCEEDS CONTRACT LIMIT.
AUTHORIZATION ISSUE	**593**	MEDICAL ADVISOR DID NOT APROVE DME RENTAL/PURCHASE.
AUTHORIZATION ISSUE	**735**	ROOM AND BOARD CHARGES FOR THE DAYS NOT APPROVED BY THE MEDICAL SERVICES ADVISOR ARE NOT ELIGIBLE FOR PAYMENT. IN ACCORDANCE WITH YOUR PARTICIPATING PROVIDER CONTRACT, THESE CHARGES (SHOWN UNDER 'PROVIDER LIABILITY') CANNOT BE BILLED TO THE PATIENT.

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AUTHORIZATION ISSUE	**736**	ROOM AND BOARD CHARGES FOR THE DAYS NOT APPROVED DURING THE PRE-CERTIFICATION PROCESS ARE NOT ELIGIBLE FOR PAYMENT.
AUTHORIZATION ISSUE	**740**	APPROVAL/CERTIFICATION FROM MENTAL HEALTH ADVISOR NOT OBTAINED PRIOR TO TREATMENT FOR SUBSTANCE ABUSE.
AUTHORIZATION ISSUE	**742**	AS A RESULT OF OUR ADMISSION REVIEW OF THIS CLAIM, ROOM CHARGES FOR THE HOSPITAL DAYS DENIED AS NOT BEING MEDICALLY NECESSARY ARE NOT ELIGIBLE FOR BENEFITS. SINCE YOU ARE A PARTICIPATING PROVIDER, THE NON COVERED ROOM CHARGES ARE REPORTED AS A 'PROVIDER LIABILITY'.
AUTHORIZATION ISSUE	**743**	AS A RESULT OF OUR ADMISSION REVIEW OF THIS CLAIM, ROOM CHARGES FOR THE HOSPITAL DAYS DENIED AS NOT BEING MEDICALLY NECESSARY ARE NOT ELIGIBLE FOR BENEFITS. SINCE YOU ARE A NON-PARTICIPATING PROVIDER, THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THESE CHARGES.
AUTHORIZATION ISSUE	**744**	AS A RESULT OF OUR ADMISSION REVIEW OF THIS CLAIM, ROOM CHARGES FOR THE HOSPITAL DAYS DENIED AS NOT BEING MEDICALLY NECESSARY ARE NOT ELIGIBLE FOR BENEFITS. THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THESE CHARGES.
AUTHORIZATION ISSUE	**751**	MENTAL HEALTH/SUBSTANCE ABUSE BENEFITS DENIED. BEHAVIORAL HEALTH ADVISOR NOT CONTACTED PRIOR TO RECEIVING TREATMENT.
AUTHORIZATION ISSUE	**752**	MENTAL HEALTH/SUBSTANCE ABUSE ADVISOR CONTACTED BUT DID NOT APPROVE THE SERVICE/TREATMENT.
AUTHORIZATION ISSUE	**768**	THIS CLAIM HAS BEEN DENIED. BENEFITS FOR THIS TYPE OF SERVICE ARE AVAILABLE ONLY IF THE PROVIDER OBTAINS PREAUTHORIZATION PRIOR TO THE PATIENT RECEIVING TREATMENT. THE SUBMITTED SERVICES WERE RECEIVED WITHOUT PRIOR APPROVAL. THE PATIENT IS NOT RESPONSIBLE FOR THESE CHARGES.
AUTHORIZATION ISSUE	**848**	THIS CLAIM HAS BEEN DENIED FOR LATE NOTIFICATON. THIS TYPE OF SERVICE REQUIRES PRE-APPROVAL BY NATIONAL HEALTH SERVICE (NHS). OUR RECORDS DO NOT SHOW THAT NHS APPROVAL WAS OBTAINED PRIOR TO RECEIVING THE SERVICE. NO FURTHER PAYMENT CAN BE MADE. MEMBER IS NOT RESPONSIBLE SINCE CLAIM/SERVICE IS FOR A FEDERAL/STATE FUNDED PROGRAM OR PROVIDER.

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AUTHORIZATION ISSUE	**853**	MEMBER'S HEALTH CARE PLAN DOES NOT PROVIDE BENEFITS FOR INPATIENT/ OUTPATIENT CARE UNLESS PRE-APPROVED BY THE PRIMARY CARE PHYSICIAN (PCP). OUR RECORDS INDICATE SERVICE(S) WERE NOT APPROVED; THEREFORE, SERVICE(S) ARE DENIED. MEMBER IS NOT LIABLE SINCE THIS CLAIM IS FOR A FEDERAL/STATE FUNDED PROGRAM OR PROVIDER.
AUTHORIZATION ISSUE	**871**	PRE-ADMISSION REVIEW OBTAINED, HOWEVER PORTIONS OF THE STAY WERE NOT APPROVED
AUTHORIZATION ISSUE	**910**	UTILIZATION PROGRAM REQUIREMENTS AS SPECIFIED IN THE PATIENT'S CONTRACT HAVE NOT BEEN FULFILLED. TO INITIATE A MEDICAL REVIEW OF THIS CLAIM, YOU OR THE PATIENT MUST CONTACT A UNITED HEALTHCARE (HEALTHMARK) ADVISOR, AT 1-800-388-1126.
AUTHORIZATION ISSUE	**915**	WE ARE UNABLE TO COMPLETE THE PROCESSING OF THIS CLAIM AT THIS TIME BECAUSE ADDITIONAL MEDICAL INFORMATION IS REQUIRED. PLEASE CONTACT TELLIGEN AT 1-800-373-3727 TO PROVIDE THIS INFORMATION.
AUTHORIZATION ISSUE	**965**	THESE SERVICES ARE NOT ELIGIBLE BECAUSE THE DATES OF SERVICES SUBMITTED ARE NOT WITHIN THE APPROVED SERVICE DATES OF THE PRIOR AUTHORIZATION ON FILE. (PENDING LEGAL APPROVAL)
AUTHORIZATION ISSUE	**01P**	PAYMENT WAS REDUCED BECAUSE THE SUBMITTED SERVICE EXCEEDS THE NUMBER OF UNITS/VISITS/DAYS APPROVED ON THE PREAUTHORIZATION AND/OR REFERRAL ON FILE. THE MEMBER IS RESPONSIBLE FOR THESE CHARGES.
AUTHORIZATION ISSUE	**02P**	PAYMENT WAS REDUCED BECAUSE THE SUBMITTED SERVICE EXCEEDS THE NUMBER OF UNITS/VISITS/DAYS APPROVED ON THE PREAUTHORIZATION AND/OR REFERRAL ON FILE. SINCE YOU ARE A PARTICIPATING PROVIDER, THE MEMBER IS NOT RESPONSIBLE FOR THESE CHARGES.
AUTHORIZATION ISSUE	**04M**	HMO SENIORS PLAN. OUT OF PLAN SERVICE COVERED IF EMERGENCY OR AUTHORIZED IN ADVANCE.
AUTHORIZATION ISSUE	**05M**	HMO SENIORS PLAN. PATIENT'S MEDICAL GROUP DID NOT APPROVE SERVICE.
AUTHORIZATION ISSUE	**10D**	CLAIM DENIED AS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LENGTH OF SERVICE.
AUTHORIZATION ISSUE	**19E**	SERVICE REQUIRES PRIOR AUTHORIZATION FROM AIM SPECIALTY HEALTH (AIM). TO HAVE YOUR CLAIM CONSIDERED FOR PAYMENT, PLEASE INITIATE A PRIOR AUTHORIZATION REQUEST DIRECTLY WITH AIM AT PROVIDERPORTAL.COM. THE PATIENT IS NOT RESPONSIBLE FOR THIS CHARGE.

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AUTHORIZATION ISSUE	**22E**	SERVICE REQUIRES PRIOR AUTHORIZATION FROM AIM SPECIALTY HEALTH (AIM). TO HAVE YOUR CLAIM CONSIDERED FOR PAYMENT, PLEASE INITIATE A PRIOR AUTHORIZATION REQUEST DIRECTLY WITH AIM AT PROVIDERPORTAL.COM. THE PATIENT IS NOT RESPONSIBLE FOR THIS CHARGE.
AUTHORIZATION ISSUE	**52D**	NUMBER OF DAYS BILLED EXCEED APPROVED DAYS. CLAIM IS IN REVIEW.
AUTHORIZATION ISSUE	**53D**	ONLY AUTHORIZED DAYS ARE ELIGIBLE FOR BENEFITS.
AUTHORIZATION ISSUE	**54D**	SERVICES WERE DENIED BECAUSE AN AUTHORIZATION WAS APPROVED FOR AN OBSERVATION STAY ONLY.
AUTHORIZATION ISSUE	**55D**	CLAIM DENIED BECAUSE PREAUTHORIZATION IS REQUIRED PER MEMBER'S BENEFIT PLAN.
AUTHORIZATION ISSUE	**56D**	THE SERVICES SUBMITTED EXCEED THE NUMBER OF VISITS PREVIOUSLY APPROVED
AUTHORIZATION ISSUE	**57D**	PRIOR AUTHORIZATION IS REQUIRED AND WAS NOT OBTAINED AND THEREFORE NOT COVERED UNDER THE MEMBER'S BENEFIT PLAN.
AUTHORIZATION ISSUE	**57H**	THESE CHARGES ARE NOT COVERED BECAUSE THE DATES ON THE TREATMENT PLAN DO NOT MATCH THE DATE(S) OF SERVICE ON THIS CLAIM. THESE CHARGES ARE THE MEMBER'S RESPONSIBILITY.
AUTHORIZATION ISSUE	**58D**	CLAIM DENIED BECAUSE REQUIRED PRE-AUTHORIZATION IS NOT ON FILE.
AUTHORIZATION ISSUE	**59D**	PROVIDER'S REQUEST FOR PRIOR AUTHORIZATION/PRECERTIFICATION WAS DENIED
AUTHORIZATION ISSUE	**59H**	THESE CHARGES ARE NOT COVERED. THIS ANESTHESIA SERVICE IS COVERED WHEN THE PROVIDER HAS RECEIVED THE APPROPRIATE CERTIFICATION ACCORDING TO OUR RECORDS, YOU HAVE NOT RECEIVED THIS CERTIFICATION.
AUTHORIZATION ISSUE	**60D**	CLAIM FILE CLOSED UNTIL PREDETERMINATION/PRIOR AUTHORIZATION REQUESTED BY PROVIDER.
AUTHORIZATION ISSUE	**63D**	ACTUAL DAYS BILLED EXCEED APPROVED DAYS ON FILE.
AUTHORIZATION ISSUE	**77H**	CLAIM PAYMENT HAS BEEN REDUCED BECAUSE AN AUTHORIZATION WAS APPROVED FOR AN OBSERVATION.

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AUTHORIZATION ISSUE	**79H**	THESE CHARGES ARE NOT ELIGIBLE BECAUSE THEY EXCEED THE MAXIMUM NUMBER OF DAYS AUTHORIZED.
AUTHORIZATION ISSUE	**AH1**	BASED ON THE AAH MEDICAL PLAN CONCIERGE MEDICAL REVIEW, INFORMATION IN THEIR FILES DOES NOT INDICATE THAT THESE SERVICES WERE MEDICALLY NECESSARY, NO PAYMENT CAN BE MADE.
AUTHORIZATION ISSUE	**AH2**	BASED ON THE AAH MEDICAL PLAN CONCIERGE MEDICAL REVIEW, INFORMATION IN THEIR FILES DOES NOT INDICATE THAT THESE SERVICES WERE MEDICALLY NECESSARY, NO PAYMENT CAN BE MADE.
AUTHORIZATION ISSUE	**AH3**	BASED ON THE AAH MEDICAL PLAN CONCIERGE MEDICAL REVIEW, INFORMATION IN THEIR FILES DOES NOT INDICATE THAT THESE SERVICES WERE MEDICALLY NECESSARY, NO PAYMENT CAN BE MADE.
AUTHORIZATION ISSUE	**AH4**	THE SERVICE HAS BEEN DENIED BECAUSE A PREAUTHORIZATION IS REQUIRED AND WAS NOT OBTAINED. NO PAYMENT FOR THIS SERVICE CAN BE MADE AT THIS TIME.
AUTHORIZATION ISSUE	**AH5**	THE SERVICE HAS BEEN DENIED BECAUSE A PREAUTHORIZATION IS REQUIRED AND WAS NOT OBTAINED. NO PAYMENT FOR THIS SERVICE CAN BE MADE AT THIS TIME.
AUTHORIZATION ISSUE	**E55**	PRECERTIFICATION WAS NOT OBTAINED FROM EVICORE, SERVICE IS DENIED.
AUTHORIZATION ISSUE	**E56**	PRECERTIFICATION WAS NOT OBTAINED FROM EVICORE, SERVICE IS DENIED.
AUTHORIZATION ISSUE	**H15**	BENEFITS FOR SERVICES WERE NOT APPROVED DURING PRECERTIFICATION.
AUTHORIZATION ISSUE	**H62**	THIS CLAIM PAYMENT HAS BEEN REDUCED BECAUSE REQUIRED PRE-AUTHORIZATION IS NOT ON FILE.
AUTHORIZATION ISSUE	**H74**	THESE CHARGES ARE NOT COVERED BECAUSE THE PATIENT HAS EXCEEDED THE NUMBER OF VISITS AUTHORIZED.
AUTHORIZATION ISSUE	**H76**	THESE CHARGES ARE NOT ELIGIBLE BECAUSE THEY EXCEED THE MAXIMUM NUMBER OF UNITS AUTHORIZED.
AUTHORIZATION ISSUE	**H84**	THESE CHARGES CANNOT BE PROCESSED BECAUSE A REFERRAL FROM THE PATIENT'S PRIMARY CARE PROVIDER HAS NOT BEEN RECEIVED. THESE CHARGES WILL BE CONSIDERED IF A REFERRAL IS SUBMITTED.
AUTHORIZATION ISSUE	**H90**	THESE CHARGES ARE NOT COVERED. THE PRIMARY CARE PROVIDER DID NOT AUTHORIZE THE SERVICES AND THE CONDITION TREATED DID NOT MEET URGENT CARE GUIDELINES.

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AUTHORIZATION ISSUE	**H91**	THESE CHARGES ARE NOT COVERED. THE PATIENT'S PRIMARY PHYSICIAN HAS NOT APPROVED THIS OUT-OF-AREA CARE.
AUTHORIZATION ISSUE	**H95**	THESE CHARGES ARE NOT COVERED. THESE SERVICES ARE SUBJECT TO PRIOR APPROVAL UNDER THE MEMBER'S BENEFIT PLAN OR POLICY.
AUTHORIZATION ISSUE	**M01**	KELSEY-SEYBOLD CLINIC IS RESPONSIBLE FOR PROCESSING THIS CLAIM. PLEASE RESUBMIT TO: KELSEY-SEYBOLD CLINIC, P.O. BOX 841209, PEARLAND, TX 77584
AUTHORIZATION ISSUE	**M02**	THIS SERVICE CAN ONLY BE CONSIDERED WHEN PREAUTHORIZED. SINCE PREAUTHORIZATION WAS NOT OBTAINED PRIOR TO RECEIVING SERVICES, NO PAYMENT CAN BE MADE.
AUTHORIZATION ISSUE	**M03**	SERVICES HAS BEEN DENIED. NO RECORD OF PRE-AUTHORIZATION FROM HMO BLUE TEXAS ON FILE, NOR WERE SERVICES PERFORMED OR ORDERED BY THE PRIMARY CARE PHYSICIAN.
AUTHORIZATION ISSUE	**M04**	SERVICE(S) NOT PERFORMED OR ORDERED BY THE PRIMARY CARE PHYSICIAN AS REQUIRED BY MEMBER'S CONTRACT. MEMBER IS RESPONSIBLE FOR PAYMENT.
AUTHORIZATION ISSUE	**M21**	MCKESSON DID NOT OBTAIN REQUIRED PREAUTHORIZATION AND/OR REFERRAL. THEREFORE, NO PAYMENT CAN BE MADE. MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THESE CHARGES.
AUTHORIZATION ISSUE	**PFR**	CLAIM PAYMENT HAS BEEN REDUCED DUE TO LATE PREAUTHORIZATION AS REQUIRED BY YOUR BLUE CROSS BLUE SHIELD OF OKLAHOMA PARTICIPATING PROVIDER CONTRACT.
AUTHORIZATION ISSUE	**PS1**	THIS COURSE OF TREATMENT WAS NOT PRE-APPROVED. NO PAYMENT CAN BE MADE THESE SERVICES WERE REVIEWED FOR MEDICAL NECESSITY, AS DEFINED UNDER THE BENEFIT PLAN AND DETERMINED NOT TO MEET THE DEFINITION. THE MEMBER IS RESPONSIBLE FOR THESE CHARGES.
AUTHORIZATION ISSUE	**T07**	HOSPITAL STAY EXCEEDED THE MUMBER OF DAYS CERTIFIED. NON-APPROVED DAYS ARE NOT COVERED.
CODING EDITING	**A03**	THE SERVICE/PROCEDURE SUBMITTED IS ONLY PAYABLE ONCE PER LIFETIME. OUR RECORDS INDICATE THE SERVICE WAS PREVIOUSLY PREFORMED. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE

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CODING EDITING	**A06**	THE SERVICE/PROCEDURE SUBMITTED IS ONLY PAYABLE A LIMITED NUMBER OF TIMES WITHIN A SPECIFIED TIME PERIOD. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A07**	THE SERVICE/PROCEDURE SUBMITTED IS ONLY PAYABLE A LIMITED NUMBER OF TIMES ON A SINGLE DATE OF SERVICE. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION OUR PROVIDER WEBSITE.
CODING EDITING	**A08**	THE SERVICE/PROCEDURE SUBMITTED IS ONLY PAYABLE A LIMITED NUMBER OF TIMES ON A SINGLE DATE OF SERVICE. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION OUR PROVIDER WEBSITE.
CODING EDITING	**A09**	THE SERVICE/PROCEDURE IS NOT PAYABLE AT THE PLACE OF SERVICE BILLED, PLEASE VERIFY CODING. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE MEMBER FOR THE BALANCE. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A11**	THE SERVICE/PROCEDURE IS NOT PAYABLE IN CONJUNCTION WITH ANOTHER SERVICE PERFORMED ON THE SAME MEMBER ON THE SAME DATE OF SERVICE. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE MEMBER FOR THE BALANCE. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A12**	THE SERVICE IS NOT PAYABLE IN CONJUNCTION WITH ANOTHER SERVICE PERFORMED ON THE SAME PATIENT AT THE SAME TIME.
CODING EDITING	**A13**	THIS SERVICE/PROCEDURE IS NOT PAYABLE WITH THE DIAGNOSIS BILLED ON THE CLAIM. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE MEMBER FOR THE BALANCE. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A14**	THIS SERVICE/PROCEDURE IS NOT PAYABLE WITH THE DIAGNOSIS BILLED ON THE CLAIM. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A15**	THE SERVICE/PROCEDURE SUBMITTED IS ONLY PAYABLE A LIMITED NUMBER OF TIMES WITHIN A SPECIFIED TIME PERIOD. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.

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CODING EDITING	**A16**	THE SERVICE/PROCEDURE SUBMITTED IS ONLY PAYABLE A LIMITED NUMBER OF TIMES WITHIN A SPECIFIED TIME PERIOD. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A19**	THE PROCEDURE CODE SUBMITTED IS NOT PAYABLE. PLEASE VERIFY CODING TO DETERMINE WHETHER A MORE SPECIFIC CODE SHOULD BE BILLED. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE MEMBER FOR THE BALANCE.
CODING EDITING	**A20**	THE PROCEDURE CODE SUBMITTED IS NOT PAYABLE. PLEASE VERIFY CODING TO DETERMINE WHETHER A MORE SPECIFIC CODE SHOULD BE BILLED. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A21**	THE UNITS BILLED EXCEED THE TOTAL ALLOWABLE UNITS. REIMBURSEMENT IS BASED ON THE TOTAL ALLOWABLE UNITS. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE MEMBER FOR THE BALANCE. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A22**	THE UNITS BILLED EXCEED THE TOTAL ALLOWABLE UNITS. REIMBURSEMENT IS BASED ON THE TOTAL ALLOWABLE UNITS. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A23**	THE SERVICE/PROCEDURE IS ALLOWED ONCE PER A LIFETIME. OUR RECORDS INDICATE WE HAVE ALREADY PAID THE MAXIMUM FOR THIS TYPE OF PROCEDURE FOR THIS MEMBER. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A24**	THIS SERVICE IS LIMITED TO A NUMBER OF PROCEDURES PERFORMED WITHIN A PERIOD OF TIME. NOT ENOUGH TIME HAS PASSED BETWEEN THE BILLED SERVICE AND A PREVIOUSLY PAID CLAIM. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE MEMBER FOR THE BALANCE. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENT'S INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**A25**	THE SERVICE/PROCEDURE IS NOT PAYABLE FOR THE PLACE OF SERVICE BILLED, PLEASE VERIFY CODING. FOR MORE INFORMATION, PLEASE REFER TO THE STANDARD AND REQUIREMENTS INFORMATION ON OUR PROVIDER WEBSITE.
CODING EDITING	**G01**	CHARGE IS AN EXACT DUPLICATE OF A CHARGE ALREADY PROCESSED ON THIS CLAIM. CODING PRACTICE UTILIZED BY THIS PARTICIPATING PROVIDER IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR BALANCE RESULTING FROM THIS CODING PRACTICE. (TEXAS SPECIFIC) NOT IN USE SINCE 5/2013

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CODING EDITING	**G03**	SERVICE IS INCIDENTAL TO THE PRIMARY PROCEDURE CODE. PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE PRIMARY SERVICE. THE CODING PRACTICE UTILIZED IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE.
CODING EDITING	**G04**	SERVICE IS INCIDENTAL TO THE PRIMARY SERVICE CODE. PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE PRIMARY SERVICE. THE CODING PRACTICE UTILIZED IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE. PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G05**	SERVICES HAVE BEEN UNBUNDLED. SEPARATELY BILLED SERVICES HAVE BEEN REBUNDLED UNDER A SINGLE CODE AS THEY ARE COMPONENTS OF THAT SAME SERVICE. THE CODING PRACTICE UTILIZED IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE.
CODING EDITING	**G06**	SERVICES HAVE BEEN UNBUNDLED. SEPARATELY BILLED SERVICES HAVE BEEN REBUNDLED UNDER A SINGLE CODE, AS THEY ARE COMPONENTS OF THE SAME SERVICE. THE CODING PRACTICE UTILIZED IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THIS CODING PRACTICE. PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G07**	SERVICES ARE MUTUALLY EXCLUSIVE. THE CLINICALLY MORE INTENSE SERVICE HAS BEEN REIMBURSED AND THE COMPARABLE SERVICES MUTUALLY EXCLUSIVE. CODING PRACTICE UTILIZED BY THIS PARTICIPATING PROVIDER IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE BALANCE RESULTING FROM THIS CODING PRACTICE.
CODING EDITING	**G08**	SERVICES ARE MUTUALLY EXCLUSIVE. THE CLINICALLY MORE INTENSE SERVICE HAS BEEN REIMBURSED AND THE COMPARABLE SERVICE IS MUTUALLY EXCLUSIVE. AS A NON-PARTICIPATING PROIVDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THIS CODING PRACTICE. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G09**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. CODING PRACTICE UTILIZED BY PARTICIPATING PROVIDER IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE BALANCE RESULTING FROM THIS CODING PRACTICE.

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CODING EDITING	**G10**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. CODING PRACTICE UTILIZED BY NON-PARTICIPATING PROVIDER IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODING PRACTICE. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G11**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. CODING PRACTICE UTILIZED BY PARTICIPATING PROVIDER IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE BALANCE RESULTING FROM THIS CODING PRACTICE.
CODING EDITING	**G12**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. CODING PRACTICE UTILIZED BY NON-PARTICIPATING PROVIDER IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THIS CODING PRACTICE. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G13**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. CODING PRACTICE UTILIZED BY PARTICIPATING PROVIDER IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE BALANCE RESULTING FROM THIS CODING PRACTICE.
CODING EDITING	**G14**	A SEPARATE CHARGE IS NOT ALLOWED, AS IT IS INCLUDED IN ANOTHER SERVICE CODING PRACTICE UTILIZED BY NON-PARTICIPATING PROVIDER IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THIS CODING PRACTICE. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G15**	PER CODING CONVENTIONS, THIS PROCEDURE CODE / MODIFIER COMBINATION IS INVALID. PLEASE RESUBMIT.
CODING EDITING	**G16**	PER CODING CONVENTIONS, THIS PROCEDURE CODE / MODIFIER COMBINATION IS INVALID. PLEASE RESUBMIT.
CODING EDITING	**G17**	THE CODE SUBMITTED IS INCONSISTENT FOR THE PATIENT'S GENDER. ADJUDICATION HAS BEEN BASED ON A CODE THAT MORE CLOSELY CORRESPONDS WITH THE PATIENT'S GENDER. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE.

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CODING EDITING	**G18**	THE CODE SUBMITTED IS INCONSISTENT WITH PATIENT'S GENDER. ADJUDICATION HAS BEEN BASED ON A CODE THAT MORE CLOSELY CORRESPONDS WITH THE PATIENT'S GENDER. AS A NON-PARTICIPATING PROVIDER, YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G19**	THE CODE SUBMITTED IS INCONSISTENT FOR THE PATIENT'S AGE. ADJUDICATION HAS BEEN BASED ON A CODE THAT MORE CLOSELY CORRESPONDS WITH THE PATIENT'S AGE. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE.
CODING EDITING	**G20**	THE CODE SUBMITTED IS INCONSISTENT FOR THE PATIENT'S AGE. ADJUDICATION HAS BEEN BASED ON A CODE THAT MORE CLOSELY CORRESPONDS WITH THE PATIENT'S AGE. AS A NON-PARTICIPATING PROVIDER, YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G21**	TOTAL UNITS BILLED (ON ONE CLAIM OR MULTIPLE CLAIMS FOR THE SAME DATE OF SERVICE) EXCEED THE TOTAL NUMBER OF LAB UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT, ON THE SAME DATE OF SERVICE. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THE BALANCE. IF THIS IS A REPEAT LAB PROCEDURE USE APPROPRIATE MODIFIER
CODING EDITING	**G22**	TOTAL UNITS BILLED (ON ONE CLAIM OR MULTIPLE CLAIMS FOR THE SAME DATE OF SERVICE) EXCEED THE TOTAL NUMBER OF LABORATORY UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT, ON THE SAME DATE OF SERVICE. IF THIS IS A REPEAT LABORATORY PROCEDURE, PLEASE USE THE APPROPRIATE MODIFIER.
CODING EDITING	**G23**	THE LABORATORY PROCEDURE(S) SUBMITTED WERE BILLED WITH A LINE QUANTITY GREATER THAN THE DATE SPAN SUBMITTED. ADDITIONAL PAYMENT IS NOT WARRANTED. IF THESE ARE REPEAT LAB PROCEDURES, PLEASE FOLLOW THE APPROPRIATE CODEING GUIDELINES. AS A PARTICIPATIING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.
CODING EDITING	**G24**	THE LABORATORY PROCEDURE(S) SUBMITTED WERE BILLED WITH A LINE QUANTITY GREATER THAN THE DATE SPAN SUBMITTED. ADDITIONAL PAYMENT IS NOT WARRANTED. IF THESE ARE REPEAT LAB PROCEDURES, PLEASE FOLLOW THE APPROPRIATE CODEING GUIDELINES.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**G25**	THE MAXIMUM NUMBER OF UNITS HAVE BEEN REPORTED FOR A SINGLE MEMBER ON A SINGLE DATE OF SERVICE. NO BENEFITS AVAILABLE BEYOND THE MAXIMUM NUMBER OF UNITS ALLOWED. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.
CODING EDITING	**G26**	THE MAXIMUM NUMBER OF UNITS HAVE BEEN REPORTED FOR A SINGLE MEMBER ON A SINGLE DATE OF SERVICE. NO BENEFITS AVAILABLE BEYOND THE MAXIMUM NUMBER OF UNITS ALLOWED.
CODING EDITING	**G27**	CERTAIN PROCEDURES HAVE BOTH A TECHNICAL AND A PROFESSIONAL COMPONENT. A SINGLE PROVIDER CAN BILL FOR BOTH COMPONENTS (GLOBAL PROCEDURE) OR DIFFERENT PROVIDERS CAN EACH BILL FOR DIFFERENT COMPONENTS. SERVICES ARE ONLY ALLOWED UP TO THE GLOBAL ALLOWANCE. THIS COMPONENT HAS PREVIOUSLY BEEN PAID. YOU MAY NOT BILL THE PATIENT FOR THIS AMOUNT. (CHANGED THE WORD BENEFIT TO SERVICES).
CODING EDITING	**G28**	CERTAIN PROCEDURES HAVE BOTH A TECHNICAL AND A PROFESSIONAL COMPONENT. A SINGLE PROVIDER CAN BILL FOR BOTH COMPONENTS (GLOBAL PROCIEDURE) OR DIFFERENT PROVIDERS CAN EACH BILL FOR DIFFERENT COMPONENTS. SERVICES ARE ONLY ALLOWED UP TO THE GLOBAL ALLOWANCE. THIS COMPONENT HAS PREVIOUSLY BEEN PAID. (CHANGED THE WORD BENEFIT TO SERVICES).
CODING EDITING	**G29**	CERTAIN PROCEDURES HAVE BOTH A TECHNICAL AND A PROFESSIONAL COMPONENT. A SINGLE PROVIDER CAN BILL FOR BOTH COMPONENTS (GLOBAL PROCIEDURE) OR DIFFERENT PROVIDERS CAN EACH BILL FOR DIFFERENT COMPONENTS. SERVICES ARE ONLY ALLOWED UP TO THE GLOBAL ALLOWANCE. THIS COMPONENT HAS PREVIOUSLY BEEN PAID. YOU MAY NOT BILL THE PATIENT FOR THIS AMOUNT. (CHANGED THE WORD BENEFIT TO SERVICES).
CODING EDITING	**G30**	CERTAIN PROCEDURES HAVE BOTH A TECHNICAL AND A PROFESSIONAL COMPONENT. A SINGLE PROVIDER CAN BILL FOR BOTH COMPONENTS (GLOBAL PROCIEDURE) OR DIFFERENT PROVIDERS CAN EACH BILL FOR DIFFERENT COMPONENTS. SERVICES ARE ONLY ALLOWED UP TO THE GLOBAL ALLOWANCE. THIS COMPONENT HAS PREVIOUSLY BEEN PAID. (CHANGED THE WORD BENEFIT TO SERVICES).
CODING EDITING	**G31**	CO-SURGEON IS NOT COVERED FOR THIS PROCEDURE. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THIS SERVICE.
CODING EDITING	**G32**	CO-SURGEON IS NOT COVERED FOR THIS PROCIEDURE

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**G33**	THE CHARGE FOR THIS TYPE OF SERVICE IS INCLUDED IN THE INITIAL OBSTETRICAL CLAIM AND MAY NOT BE BILLED SEPARATELY. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THIS SERVICE.
CODING EDITING	**G34**	THE CHARGE FOR THIS TYPE OF SERVICE IS INCLUDED IN THE INITIAL OBSTETRICAL CLAIM AND MAY NOT BE BILLED SEPARATELY.
CODING EDITING	**G37**	SERVICE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO THE PRIMARY PROCEDURE. THIS CODING PRACTICE IS INCONSISTENT WITH CURRENT NCCI CODING PROTOCOL. PATIENT MAY NOT BE BILLED FOR THE BALANCE. GO TO WWW.BCBSIL/TX/OK/NM/MT.COM/PROVIDER FOR ADDITIONAL INFORMATION ON CLAIM PROCESSING TOOLS AND EDITS USED BY YOUR CORRESPONDING STATE.
CODING EDITING	**G38**	SERVICE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO PRIMARY PROCEDURE. THIS CODING PRACTICE IS INCONSISTENT WITH CURRENT NCCI CODING PROTOCOL. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THIS CODING PRACTICE. GO TO WWW.BCBSIL/TX/OK/NM/MT.COM/PROVIDER FOR ADDITIONAL INFORMATION USED BY CORRESPONDING STATE.
CODING EDITING	**G39**	DURABLE MEDICAL EQUIPMENT SERVICES INDICATES A RENTAL CHARGE. PREVIOUS CHARGES INDICATES MEMBER HAS PURCHASED THS DME ITEM. THE PATIENT IS RESPONSIBLE FOR THIS CHARGE. (TBD NOT CURRENTLY BEING UTILIZED)
CODING EDITING	**G40**	DURABLE MEDICAL EQUIPMENT SERVICES INDICATES A RENTAL CHARGE. PREVIOUS CHARGES INDICATES MEMBER HAS PURCHASED THS DME ITEM. THE PATIENT IS RESPONSIBLE FOR THIS CHARGE. (TBD NOT CURRENTLY BEING UTILIZED)
CODING EDITING	**G41**	DURABLE MEDICAL EQUIPMENT SERVICES INDICATES A PURCHASE CHARGE. PREVIOUS CHARGES INDICATES MEMBER HAS PURCHASED THS DME ITEM. THE PATIENT IS RESPONSIBLE FOR THIS CHARGE (TBD NOT CURRENTLY BEING UTILIZED)
CODING EDITING	**G42**	DURABLE MEDICAL EQUIPMENT SERVICES INDICATES A PURCHASE CHARGE. PREVIOUS CHARGES INDICATES MEMBER HAS PURCHASED THS DME ITEM. THE PATIENT IS RESPONSIBLE FOR THIS CHARGE (TBD NOT CURRENTLY BEING UTILIZED)
CODING EDITING	**G43**	THE MAXIMUM ALLOWANCE FOR THE DME HAS BEEN EXCEEDED; AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THE BALANCE (TBD NOT CURRENTLY BEING UTILIZED)

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**G45**	DURABLE MEDICAL EQUIPEMENT BILLED EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THE BALANCE
CODING EDITING	**G46**	DURABLE MEDICAL EQUIPMENT CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED. THE PATIENT IS RESPONSIBLE FOR THIS CHARGE.
CODING EDITING	**G47**	THE CHARGES SUBMITTED HAVE EXCEEDED THE RECOMMENDED NUMBER OF SUPPLIES FOR THE CPAP/BIPAP ITEM
CODING EDITING	**G48**	THE CHARGES SUBMITTED HAVE EXCEEDED THE RECOMMENDED NUMBER OF SUPPLIES FOR THE CPAP/BIPAP ITEM. PATIENT IS RESPONSIBLE FOR THIS CHARGE.
CODING EDITING	**G51**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME MEMBER, ON THE SAME DATE OF SERVICE. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.
CODING EDITING	**G52**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT ON THE SAME DATE OF SERVICE. THE PATIENT IS RESPONSIBLE FOR THIS CHARGE.
CODING EDITING	**G53**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT ON THE SAME DATE OF SERVICE. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**G54**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT ON THE SAME DATE OF SERVICE. THE PATIENT IS RESPONSIBLE FOR THIS CHARGE.
CODING EDITING	**G55**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT ON THE SAME DATE OF SERVICE. AS A PARTICIPATING PROVIDER, YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.
CODING EDITING	**G56**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT ON THE SAME DATE OF SERVICE. THE PATIENT IS RESPONSIBLE FOR THIS CHARGE
CODING EDITING	**G57**	THE DIAGNOSIS BILLED ON THE CLAIM IS NOT COVERED WITH THE PROCEDURE CODE BILLED, AND SHOULD BE BILLED WITH AN APPROPRIATE PROCEDURE CODE TO DIAGNOSIS CODE. NO PAYMENT CAN BE MADE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**G58**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED FOR THIS DRUG AND DIAGNOSIS COMBINATION ON THE SAME DATE OF SERVICE. UNITS OVER THE ALLOWED AMOUNT ARE NOT PAYABLE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**G59**	THE PROCEDURE DRUG CODE BILLED IS NOT APPROPRIATE FOR THE PATIENT AGE, AND SHOULD BE BILLED WITH THE APPROPRIATE CODE. NO PAYMENT CAN BE MADE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE
CODING EDITING	**G60**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED FOR THE DRUG BASED UPON THE AGE OF THE PATIENT. UNITS OVER THE ALLOWED AMOUNT ARE NOT PAYABLE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**G61**	SERVICE IS INCIDENTAL TO THE PRIMARY PROCEDURE CODE. PAYMENT IS INCLUDED IN THE ALLOWANCE FOR THE PRIMARY SERVICE. THE CODING PRACTICE UTILIZED IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE.
CODING EDITING	**G62**	SERVICES ARE MUTUALLY EXCLUSIVE. THE CLINICALLY MORE INTENSE SERVICE HAS BEEN REIMBURSED AND THE COMPARABLE SERVICE IS MUTUALLY EXCLUSIVE. CODING PRACTICE UTILIZED IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**G63**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT, ON THE SAME DATE OF SERVICE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**G64**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT, ON THE SAME DATE OF SERVICE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**G65**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT, ON THE SAME DATE OF SERVICE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**G66**	SERVICE IS INCIDENTAL OR MUTUALLY EXCLUSIVE TO THE PRIMARY PROCEDURE. THIS CODING PRACTICE IS INCONSISTENT WITH CURRENT NCCI CODING PROTOCOL. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**G67**	SERVICES HAVE BEEN UNBUNDLED. SEPARATELY BILLED SERVICES HAVE BEEN REBUNDLED UNDER A SINGLE CODE, AS THEY ARE COMPONENTS OF THAT SAME SERVICE. THE CODING PRACTICE UTILIZED IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE.
CODING EDITING	**G68**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED FOR THE PROCEDURE CODE BILLED ON THE DATE OF SERVICE. UNITS OVER THE ALLOWED AMOUNT ARE NOT PAYABLE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**G69**	THE PROCEDURE CODE BILLED IS INCONSISTENT WITH THE DIAGNOSIS SUBMITTED. NO PAYMENT CAN BE MADE. PLEASE RESUBMIT THE CLAIM WITH THE APPROPRIATE DIAGNOSIS CODE RELATED TO THE BILLED PROCEDURE CODE. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**G70**	THE PROCEDURE CODE BILLED IS INCONSISTENT WITH THE DIAGNOSIS SUBMITTED. NO PAYMENT CAN BE MADE. PLEASE RESUBMIT THE CLAIM WITH THE APPROPRIATE DIAGNOSIS CODE RELATED TO THE BILLED PROCEDURE CODE. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE. PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G71**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED FOR THIS DRUG AND DIAGNOSIS COMBINATION ON THE SAME DATE OF SERVICE. UNITS OVER THE ALLOWED AMOUNT ARE NOT PAYABLE. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE BALANCE
CODING EDITING	**G72**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED FOR THIS DRUG AND DIAGNOSIS COMBINATION ON THE SAME DATE OF SERVICE. UNITS OVER THE ALLOWED AMOUNT ARE NOT PAYABLE. NO ADDITIONAL PAYMENT CAN BE MADE.
CODING EDITING	**G73**	THE PROCEDURE DRUG CODE BILLED IS NOT APPROPRIATE FOR THE PATIENT AGE, AND SHOULD BE BILLED WITH THE APPROPRIATE CODE. NO PAYMENT CAN BE MADE. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.
CODING EDITING	**G74**	THE PROCEDURE DRUG CODE BILLED IS NOT APPROPRIATE FOR THE PATIENT AGE, AND SHOULD BE BILLED WITH THE APPROPRIATE CODE. NO PAYMENT CAN BE MADE. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE. PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G75**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED FOR THE DRUG BASED UPON THE AGE OF THE PATIENT. UNITS OVER THE ALLOWED AMOUNT ARE NOT PAYABLE. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.
CODING EDITING	**G76**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED FOR THE DRUG BASED UPON THE AGE OF THE PATIENT. UNITS OVER THE ALLOWED AMOUNT ARE NOT PAYABLE. NO ADDITIONAL PAYMENT CAN BE MADE.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**G77**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED FOR THE PROCEDURE CODE BILLED ON THE DATE OF SERVICE. UNITS OVER THE ALLOWED AMOUNT ARE NOT PAYABLE. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.
CODING EDITING	**G78**	CHARGE EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED FOR THE PROCEDURE CODE BILLED ON THE DATE OF SERVICE. UNITS OVER THE ALLOWED AMOUNT ARE NOT PAYABLE. NO ADDITIONAL PAYMENT CAN BE MADE.
CODING EDITING	**G79**	CERTAIN PROCEDURES HAVE BOTH A TECHNICAL AND A PROFESSIONAL COMPONENT. A SINGLE PROVIDER CAN BILL FOR BOTH COMPONENTS (GLOBAL PROCEDURE), OR DIFFERENT PROVIDERS CAN EACH BILL FOR DIFFERENT COMPONENTS. SERVICES ARE ONLY ALLOWED UP TO THE GLOBAL ALLOWANCE. THIS COMPONENT HAS PREVIOUSLY BEEN PAID. YOU MAY NOT BILL THE HMO ILLINOIS PATIENT FOR THIS AMOUNT.
CODING EDITING	**G80**	CLAIMS SUBMITTED BY AN OUTPATIENT FACILITY PROVIDER OR HOSPITAL MUST INCLUDE A SUPPORTING HCPCS OR CPT CODE WITH A REVENUE CODE. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**G81**	THE CODE SUBMITTED IS NOT APPROPRIATE FOR THE PATIENT STATUS. ADJUDICATION HAS BEEN BASED ON A CODE THAT CORRESPONDS WITH THE PATIENT STATUS. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE BALANCE.
CODING EDITING	**G82**	THE CODE SUBMITTED IS NOT APPROPRIATE FOR THE PATIENT STATUS. ADJUDICATION HAS BEEN BASED ON A CODE THAT CORRESPONDS WITH THE PATIENT STATUS. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL. THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G83**	THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. THE PRIMARY PROCEDURE CODE WAS NOT SUBMITTED THEREFORE, THE ADD-ON CODE IS NOT ALLOWED. NO PAYMENT CAN BE MADE. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE PATIENT FOR THE DISALLOWED CODE.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**G84**	THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. THE PRIMARY PROCEDURE CODE WAS DENIED OR NOT SUBMITTED THEREFORE, THE ADD-ON CODE IS NOT ALLOWED. NO PAYMENT CAN BE MADE. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G85**	CLAIMS SUBMITTED BY AN OUTPATIENT FACILITY PROVIDER OR HOSPITAL MUST INCLUDE A SUPPORTING HCPCS OR CPT CODE WITH A REVENUE CODE. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A PARTICIPATING PROVIDER, PATIENT CANNOT BE BILLED FOR THE BALANCE
CODING EDITING	**G86**	CLAIMS SUBMITTED BY AN OUTPATIENT FACILITY PROVIDER OR HOSPITAL MUST INCLUDE A SUPPORTING HCPCS OR CPT CODE WITH A REVENUE CODE. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE. PATIENT HAS BEEN NOTIFIED
CODING EDITING	**G87**	BILLING THE SAME BILATERAL PROCEDURE CODE TWO OR MORE TIMES ON THE SAME DATE OF SERVICE IS NOT ALLOWED. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A PARTICIPATING PROVIDER YOU MAY NOT BILL THE MEMBER FOR THE BALANCE.
CODING EDITING	**G88**	BILLING THE SAME BILATERAL PROCEDURE CODE TWO OR MORE TIMES ON THE SAME DATE OF SERVICE IS NOT ALLOWED. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE. PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**G89**	MULTIPLE EVALUATION AND MANAGEMENT CODES FOR THE SAME DATE OF SERVICE MUST HAVE THE -27 MODIFIER ON THE SECOND AND SUBSEQUENT CODES. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A PARTICIPATING PROVIDER, PATIENT CANNOT BE BILLED FOR THE BALANCE.
CODING EDITING	**G90**	MULTIPLE EVALUATION AND MANAGEMENT CODES FOR THE SAME DATE OF SERVICE MUST HAVE THE -27 MODIFIER ON THE SECOND AND SUBSEQUENT CODES. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE. PATIENT HAS BEEN NOTIFIED

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**G91**	MULTIPLE EVALUATION AND MANAGEMENT CODES FOR THE SAME DATE OF SERVICE MUST HAVE THE -27 MODIFIER ON THE SECOND AND SUBSEQUENT CODES. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE
CODING EDITING	**G93**	THIS PROCEDURE CAN ONLY BE RECEIVED ONCE OR TWICE IN A PATIENT'S LIFETIME. OUR RECORDS INDICATE WE HAVE ALREADY PAID FOR THIS TYPE OF PROCEDURE FOR THIS PATIENT. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A PARTICIPATING PROVIDER, PATIENT CANNOT BE BILLED FOR THE BALANCE.
CODING EDITING	**G94**	THIS PROCEDURE CAN ONLY BE RECEIVED ONCE OR TWICE IN A PATIENT'S LIFETIME PER THE MEMBER'S BENEFIT PLAN. WE HAVE ALREADY PAID THE MAXIMUM FOR THIS TYPE OF PROCEDURE FOR THIS PATIENT. CODING PRACTICE IS INCONSISTENT WITH CURRENT CODING PROTOCOL. YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM YOUR CODING PRACTICE. PATIENT NOTIFIED
CODING EDITING	**V01**	THE PRIMARY SERVICE CODE WAS NOT SUBMITTED THEREFORE THE SECONDARY CODE IS NOT ALLOWED. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V02**	THE PRIMARY SERVICE CODE WAS NOT SUBMITTED THEREFORE THE SECONDARY CODE IS NOT ALLOWED. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V07**	THIS SERVICE IS INCIDENTAL/MUTUALLY EXCLUSIVE TO THE PRIMARY PROCEDURE. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT NCCI CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V08**	THIS SERVICE IS INCIDENTAL/MUTUALLY EXCLUSIVE TO THE PRIMARY PROCEDURE THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT NCCI CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**V09**	THE CODE SUBMITTED IS NOT CONSISTENT WITH CODING PROTOCOLS IN EFFECT ON THE DATE OF SERVICE. THE PARTICIPATING PROVIDER CANNOT BILL YOU FOR THE DISALLOWED CODE.
CODING EDITING	**V10**	THE CODE SUBMITTED IS NOT CONSISTENT WITH CODING PROTOCOLS IN EFFECT ON THE DATE OF SERVICE. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V11**	THE SERVICE BILLED IS A DUPLICATE OF A CHARGE ALREADY PROCESSED. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V12**	THE SERVICE BILLED IS A DUPLICATE OF A CHARGE ALREADY PROCESSED. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V13**	THE SERVICE BILLED EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT, ON THE SAME DATE OF SERVICE. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V14**	THE SERVICE BILLED EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY SAME PROVIDER, FOR SAME PATIENT, ON SAME DATE OF SERVICE.THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR BALANCE RESULTING FROM THE CODE BILLED. PATIENT NOTIFIED.
CODING EDITING	**V15**	THE SERVICE IS INCLUDED IN THE GLOBAL SURGICAL PACKAGE, THEREFORE IS NOT SEPARATELY REIMBURSABLE. THE PARTICIPATING PROVIDER CANNOT BILL YOU FOR THE DISALLOWED CODE.
CODING EDITING	**V16**	THE SERVICE IS INCLUDED IN THE GLOBAL SURGICAL PACKAGE, THEREFORE IS NOT SEPARATELY REIMBURSABLE. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
		YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V17**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOLS. PATIENT CANNOT BE BILLED FOR THE DISALLOWED SERVICE.
CODING EDITING	**V18**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V19**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. THE PARTICIPATING PROVIDER CANNOT BILL YOU FOR THE DISALLOWED CODE.
CODING EDITING	**V20**	THIS SERVICE IS A BUNDLED OR AN EXCLUDED CODE AND A SEPARATE CHARGE IS NOT ALLOWED. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V21**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED SERVICE
CODING EDITING	**V22**	A SEPARATE CHARGE IS NOT ALLOWED AS IT IS INCLUDED IN ANOTHER SERVICE. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V23**	THE CODE/MODIFIER COMBINATION IS NOT CONSISTENT WITH CODING PROTOCOLS. PLEASE RESUBMIT. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOLS. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V24**	THE PROCEDURE CODE/MODIFIER COMBINATION SUBMITTED IS NOT CONSISTENT WITH CODING PROTOCOLS. PLEASE RESUBMIT. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**V25**	THE LABORATORY PROCEDURE WAS PREVIOUSLY SUBMITTED, THEREFORE SEPARATE BENEFITS ARE NOT ALLOWED. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED SERVICE.
CODING EDITING	**V26**	SERVICES HAVE BEEN UNBUNDLED. PLEASE RESUBMIT USING APPROPRIATE CODE. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V29**	THIS SERVICE WAS SUBMITTED WITH UNITS EXCEEDING THE MUE THRESHOLD. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V30**	THIS SERVICE WAS SUBMITTED WITH UNITS EXCEEDING THE MUE THRESHOLD. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V31**	YOUR HEALTH CARE PLAN COVERS THE SERVICES OF A CO-SURGEON WHEN THE COMPLEXITY OF THE SURGICAL PROCEDURE REQUIRES SUCH ASSISTANCE. THE INFORMATION RECEIVED INDICATES THE SURGICAL PROCEDURE PERFORMED DID NOT MEET THIS REQUIREMENT. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V32**	THE PATIENT'S HEALTH CARE PLAN COVERS THE SERVICES OF A CO-SURGEON WHEN THE COMPLEXITY OF THE SURGICAL PROCEDURE REQUIRES SUCH ASSISTANCE THE INFORMATION RECEIVED INDICATES THE SURGICAL PROCEDURE PERFORMED DID NOT MEET THIS REQUIREMENT. NO BENEFITS AVAILABLE FOR THIS SERVICE THE PROVIDER MAY NOT BILL THE PATIENT FOR THIS SERVICE.
CODING EDITING	**V33**	THE SERVICE BILLED EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT, ON THE SAME DATE OF SERVICE. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V34**	THE SERVICE BILLED EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT, ON THE SAME DATE OF SERVICE. PATIENT

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
		WAS NOTIFIED TO DISCUSS THIS MATTER WITH THE PROVIDER IF BILLED FOR THE DISALLOWED SERVICE
CODING EDITING	**V35**	THE E/M SERVICE SUBMITTED IS A NEW PATIENT SERVICE. THERE IS A SIMILAR SERVICE FOR THIS PATIENT IN THE PAST THREE YEARS, THEREFORE THE SERVICE HAS BEEN REPLACED WITH AN EQUIVALENT SERVICE LEVEL FOR AN ESTABLISHED PATIENT. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED SERVICE.
CODING EDITING	**V36**	THE E/M SERVICE SUBMITTED HAS BEEN BILLED THE MAXIMUM AMOUNT OF TIMES WITHIN THE ALLOWED DATE RANGE. PLEASE RESUBMIT USING APPROPRIATE CODE. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V37**	THE SERVICE BILLED IS INCLUDED IN THE INITIAL OBSTETRICAL CLAIM AND MAY NOT BE BILLED SEPARATELY. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED SERVICE.
CODING EDITING	**V38**	THE SERVICE BILLED IS INCLUDED IN A PREVIOUSLY SUBMITTED OBSTETRICAL CLAIM AND MAY NOT BE BILLED SEPARATELY. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V41**	SERVICES HAVE BEEN UNBUNDLED. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V42**	SERVICES HAVE BEEN UNBUNDLED. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOL. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V43**	THE PRIMARY SERVICE CODE WAS NOT SUBMITTED THEREFORE THE SECONDARY CODE IS NOT ALLOWED. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**V44**	SERVICE IS INCIDENTAL/MUTUALLY EXCLUSIVE TO THE PRIMARY PROCEDURE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**V45**	THE CODE SUBMITTED IS NOT CONSISTENT WITH CODING PROTOCOLS IN EFFECT ON THE DATE OF SERVICE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**V46**	THE SERVICE BILLED IS A DUPLICATE OF A CHARGE ALREADY PROCESSED ON THIS CLAIM. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**V47**	THE CODE/MODIFIER COMBINATION SUBMITTED IS NOT CONSISTENT WITH CODING PROTOCOLS. PLEASE RESUBMIT. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**V48**	THE LABORATORY PROCEDURE WAS PREVIOUSLY SUBMITTED THEREFORE, SEPARATE BENEFITS ARE NOT WARRANTED. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**V49**	THIS SERVICE WAS SUBMITTED WITH UNITS EXCEEDING THE MUE THRESHOLD. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**V50**	SERVICES HAVE BEEN UNBUNDLED. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE
CODING EDITING	**V51**	THE SERVICE BILLED EXCEEDS THE TOTAL NUMBER OF UNITS ALLOWED WHEN BILLED BY THE SAME PROVIDER, FOR THE SAME PATIENT, ON THE SAME DATE OF SERVICE. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**V52**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**V53**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. PATIENT CANNOT BE BALANCE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V54**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. AS A NON PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V55**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. PATIENT CANNOT BE BALANCE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V56**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. AS A NON PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V57**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. PATIENT CANNOT BE BALANCE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V58**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. AS A NON PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V59**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. PATIENT CANNOT BE BALANCE BILLED FOR THE DISALLOWED CODE.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**V60**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. AS A NON PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V61**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. AS A NON PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V62**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. PATIENT WAS NOTIFIED TO DISCUSS THIS MATTER WITH THE PROVIDER IF BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V63**	AFTER REVIEW OF CLAIMS DATA, THE SUBMITTED MODIFIER(S) COULD NOT BE VALIDATED; THEREFORE, PAYMENT CANNOT BE MADE. FOR RECONSIDERATION OF PAYMENT, PLEASE SUBMIT RECORDS FOR FURTHER REVIEW. YOU MAY NOT BILL THE HMOI PATIENT FOR THE BALANCE.
CODING EDITING	**V64**	THE PROCEDURE CODE WAS NOT SUBMITTED WITH THE APPROPRIATE ANATOMICAL MODIFIER. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOLS. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED
CODING EDITING	**V65**	THE PROCEDURE CODE WAS NOT SUBMITTED WITH THE APPROPRIATE ANATOMICAL MODIFIER. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOLS. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V66**	INFORMATION AND DIAGNOSIS CODE(S) SUBMITTED ARE INCONSISTENT WITH ICD-10-CM CODING GUIDELINES AND CURRENT CODING PROTOCOLS. NO MEDICAL RECORDS ARE NECESSARY AT THIS TIME. PLEASE SUBMIT A CORRECTED CLAIM. AS A NON-PARTICIPATING PROVIDER YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. PATIENT NOTIFIED.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
CODING EDITING	**V67**	THE DIAGNOSIS CODE(S) SUBMITTED IS INCONSISTENT WITH ICD-10-CM CODING GUIDELINES. NO MEDICAL RECORDS ARE NECESSARY AT THIS TIME. PLEASE SUBMIT A CORRECTED CLAIM. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V68**	THE DIAGNOSIS/PROCEDURE COMBINATION OR DIAGNOSIS/MODIFIER COMBINATION SUBMITTED IS NOT CONSISTENT WITH CODING PROTOCOLS. PLEASE RESUBMIT. AS A NON-PARTICIPATING PROVIDER, YOU SHOULD NOT BILL THE PATIENT FOR THE BALANCE RESULTING FROM THE CODE BILLED. THE PATIENT HAS BEEN NOTIFIED.
CODING EDITING	**V69**	THE DIAGNOSIS/PROCEDURE COMBINATION OR DIAGNOSIS/MODIFIER COMBINATION SUBMITTED IS NOT CONSISTENT WITH CODING PROTOCOLS. PLEASE RESUBMIT. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOLS. PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V72**	THE PROCEDURE CODE WAS NOT SUBMITTED WITH THE APPROPRIATE ANATOMICAL MODIFIER. THE INFORMATION SUBMITTED ON THE CLAIM IS INCONSISTENT WITH CURRENT CODING PROTOCOLS. HMOI PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
CODING EDITING	**V73**	THE DIAGNOSIS CODE(S) SUBMITTED IS INCONSISTENT WITH ICD-10-CM CODING GUIDELINES. NO MEDICAL RECORDS ARE NECESSARY AT THIS TIME. PLEASE SUBMIT A CORRECTED CLAIM. HMOI PATIENT CANNOT BE BILLED FOR THE DISALLOWED CODE.
DISPUTE PRE PAY	**361**	THE SERVICE/DIAGNOSIS IS NOT ELIGIBLE FOR REIMBURSEMENT AFTER REVIEW OF THE CLAIM/DOCUMENTATION RECEIVED. SOME EXAMPLES INLUDE MISSING/INSUFFICIENT RECORDS/ORDERS, AND/OR CLAIM BILLING ERRORS, OR POLICY CRITERIA WAS NOT MET. PLEASE VISIT OUR WEBSITE FOR MORE INFORMATION.
DISPUTE PRE PAY	**940**	AN AUDIT HAS DETERMINED THE AMOUNT FOR A PROCEDURE WAS FOUND TO BE INCOMPATIBLE WITH AN ESTABLISHED PATIENT VISIT. PATIENT IS NOT RESPONSIBLE FOR THESE CHARGES.
DISPUTE PRE PAY	**05D**	THIS CLAIM REVIEWED AT THE REQUEST OF THE HOST PLAN.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
DISPUTE PRE PAY	**32D**	THIS CLAIM HAS BEEN DENIED DUE TO POSSIBLE ERROR. THE CLAIM IS UNDER REVIEW.
DISPUTE PRE PAY	**90D**	CHARGES EXCEED THE ALLOWED AMOUNT FOR THIS SERVICE. SERVICES PROVIDED BY A PARTICIPATING/NETWORK PROVIDER. PATIENT IS NOT RESPONSIBLE.
DISPUTE PRE PAY	**91D**	THE ALLOWED AMOUNT EXCEEDS THE BILLED AMOUNT FOR THE SERVICE. SERVICES PROVIDED BY A PARTICIPATING/NETWORK PROVIDER. PATIENT IS NOT RESPONSIBLE
DISPUTE PRE PAY	**H26**	CLAIM INVESTIGATION NEEDED.
DISPUTE PRE PAY	**LOC**	THE CLAIM SUBMITTED DOES NOT MATCH THE ASSOCIATED MEDICAL RECORDS/DOCUMENTATION RECEIVED FOR THE LEVEL OF CARE THAT WAS PROVIDED. SERVICES WERE ALLOWED AT THE LEVEL OF CARE CONSISTENT WITH THE MEDICAL RECORDS/DOCUMENTATION.
DISPUTE PRE PAY	**LOD**	THE CLAIM SUBMITTED DOES NOT MATCH THE ASSOCIATED MEDICAL RECORDS/DOCUMENTATION RECEIVED FOR THE LEVEL OF CARE THAT WAS PROVIDED. SERVICES WERE ALLOWED AT THE LEVEL OF CARE CONSISTENT WITH THE MEDICAL RECORDS/DOCUMENTATION.
DISPUTE PRE PAY	**LOE**	THE MEDICAL RECORDS/DOCUMENTATION RECEIVED FOR THE SUBMITTED CLAIM INDICATE A HIGHER LEVEL OF CARE THAN BILLED. SERVICES WERE ALLOWED AT THE HIGHER LEVEL OF CARE CONSISTENT WITH THE MEDICAL RECORDS/DOCUMENTATION.
DISPUTE PRE PAY	**LOF**	THE MEDICAL RECORDS/DOCUMENTATION RECEIVED FOR THE SUBMITTED CLAIM INDICATE A HIGHER LEVEL OF CARE THAN BILLED. SERVICES WERE ALLOWED AT THE HIGHER LEVEL OF CARE CONSISTENT WITH THE MEDICAL RECORDS/DOCUMENTATION. AN APPEAL MAY BE SUBMITTED.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**355**	MEDICAL NECESSITY DENIAL- INPATIENT SERVICE.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**356**	MEDICAL NECESSITY DENIAL - HOSPITAL CARE NOT REQUIRED.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**357**	MEDICAL NECESSITY DENIAL-EXCESSIVE PASSES.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**753**	AS A RESULT OF OUR UTILIZATION MANAGEMENT REVIEW (URA) OF THIS CLAIM, ROOM CHARGES FOR THE HOSPITAL DAYS DENIED AS NOT BEING MEDICALLY NECESSARY ARE NOT ELIGIBLE FOR BENEFITS.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**762**	SERVICES DETERMINED NOT TO BE MEDICALLY NECESSARY. SINCE THE PROVIDER DOES NOT PARTICIPATE IN A CONTRACTING PROVIDER NETWORK, THE MEMBER IS RESPONSIBLE FOR THE PAYMENT OF THESE CHARGES.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**845**	SERVICES FOR BULK POWDER OR COMPOUND DRUGS ARE CONSIDERED EXPERIMENTAL INVESTIGATIONAL, OR UNPROVEN AND NOT COVERED UNDER THE MEMBER'S BENEFIT PLAN. THIS IS A CONTRACTED PROVIDER, THE MEMBER IS NOT RESPONSIBLE FOR PAYMENT OF THESE CHARGES.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**846**	SERVICES FOR BULK POWDER OR COMPOUND DRUGS ARE CONSIDERED EXPERIMENTAL INVESTIGATIONAL, OR UNPROVEN AND ARE NOT COVERED UNDER THE MEMBER'S BENEFIT PLAN. SINCE THE PROVIDER DOES NOT PARTICIPATE IN A CONTRACTING PROVIDER NETWORK, THE MEMBER IS RESPONSIBLE FOR PAYMENT OF THESE CHARGES.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**847**	SERVICES FOR BULK POWDER OR COMPOUND DRUGS ARE CONSIDERED EXPERIMENTAL INVESTIGATIONAL, OR UNPROVEN AND ARE NOT COVERED UNDER THE MEMBER'S BENEFIT PLAN. THE MEMBER WILL BE RESPONSIBLE FOR PAYMENT OF THESE CHARGES.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**936**	THE AVAILABILITY OF BENEFITS FOR THE REQUESTED SERVICE(S)WAS REVIEWED BY THE ACCOUNT OR THE ACCOUNT'S THIRD PARTY UTILIZATION VENDOR, AND IT WAS DETERMINED THAT MEDICAL NECESSITY WAS NOT ESTABLISED. THEREFORE, THERE ARE NO BENEFITS AVAILABLE UNDER THE MEMBER'S HEALTH PLAN.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**961**	THE MEDICAL POLICY REVIEW DEPARTMENT HAS DETERMINED THAT THE SERVICE PROVIDED IS NOT COVERED BASED ON CORPORATE MEDICAL POLICY CRITERIA.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**02D**	CLAIM DENIED BASED ON INFORMATION PROVIDED. SPECIFIC REQUESTED MEDICAL INFORMATION SHOULD BE PROVIDED FOR APPEAL/RECONSIDERATION OF THIS CLAIM.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**06D**	CLAIM DENIED. PROCEDURE/TREATMENT HAS NOT BEEN DEEMED PROVEN TO BE EFFECTIVE.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**07H**	THIS CHARGE IS NOT COVERED. SERVICES RELATED TO EXPERIMENTAL PROCEDURES ARE EXCLUDED UNDER THE PATIENT'S BENEFIT OR POLICY.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**26D**	SERVICES/PROCEDURES ARE EXPERIMENTAL/INVESTIGATIONAL AND ARE THEREFORE NOT A COVERED BENEFIT.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**90H**	SERVICES THAT ARE NOT GENERALLY ACCEPTED IN THE MEDICAL COMMUNITY AND/OR NOT PROVEN TO BE EFFECTIVE ACCORDING TO PEER REVIEWED CLINICAL LITERATURE ARE NOT COVERED. THE MEMBER MAY BE RESPONSIBLE FOR PAYMENT OF THESE CHARGES.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**H66**	THESE SERVICES ARE NOT COVERED BECAUSE THEY WERE PROVIDED IN AN INPATIENT SETTING WHICH WAS DETERMINED TO BE NOT MEDICALLY NECESSARY. THESE CHARGES ARE THE MEMBER'S RESPONSIBILITY.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**H68**	YOUR DENTAL CONTRACT DOES NOT COVER CHARGES FOR TREATMENT, SERVICES OR SUPPLIES THAT DO NOT MEET GROUPS CRITERIA FOR MEDICAL NECESSITY OR ARE NOT NORMALLY PROVIDED FOR THE TREATMENT OF THIS CONDITION.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**MEW**	OUR RECORDS INDICATE THAT THE PREMIUM FOR THIS SUBSCRIBER'S ACCOUNT HAS NOT BEEN RECEIVED. THEREFORE, BENEFITS ARE NOT AVAILABLE WHILE THE PREMIUM REMAINS OUTSTANDING.
EXPERIMENTAL/INVESTIGATIONAL/MEDICAL NECESSITY	**ORC**	SERVICES DETERMINED NOT TO BE MEDICALLY NECESSARY AS DEFINED UNDER THE PLAN. THE CLAIM IS DENIED. THE MEMBER IS NOT RESPONSIBLE FOR THESE CHARGES.
PRE-PAY REVIEW	**LOD**	THE CLAIM SUBMITTED DOES NOT MATCH THE ASSOCIATED MEDICAL RECORDS/DOCUMENTATION RECEIVED FOR THE LEVEL OF CARE THAT WAS PROVIDED. SERVICES WERE ALLOWED AT THE LEVEL OF CARE CONSISTENT WITH THE MEDICAL RECORDS/DOCUMENTATION.
PRE-PAY REVIEW	**LOE**	THE MEDICAL RECORDS/DOCUMENTATION RECEIVED FOR THE SUBMITTED CLAIM INDICATE A HIGHER LEVEL OF CARE THAN BILLED. SERVICES WERE ALLOWED AT THE HIGHER LEVEL OF CARE CONSISTENT WITH THE MEDICAL RECORDS/DOCUMENTATION.
PRE-PAY REVIEW	**LOF**	THE MEDICAL RECORDS/DOCUMENTATION RECEIVED FOR THE SUBMITTED CLAIM INDICATE A HIGHER LEVEL OF CARE THAN BILLED. SERVICES WERE ALLOWED AT THE HIGHER LEVEL OF CARE CONSISTENT WITH THE MEDICAL RECORDS/DOCUMENTATION. AN APPEAL MAY BE SUBMITTED.
NSA OR SENATE BILL RELATED TO ER	**T97**	UNDER THE TEXAS LAW,A MEMBER MUST NOT BE BILLED ABOVE THEIR COST-SHARE FOR NON-NETWORK ER CARE,FACILITY-BASED CARE OR LAB/DIAGNOSTIC IMAGING. IF YOU DISAGREE WITH THE PAYMENT AMOUNT, YOU CAN REQUEST MEDIATION OR ARBITRATION BY SUBMITTING A REQUEST AT WWW.TDI.TEXAS.GOV. ONCE SUBMITTED, PLEASE NOTIFY BCBSTX AT TX.PROVIDER.ARBITRATION@BCBSTX.COM.
NSA OR SENATE BILL RELATED TO ER	**T98**	MEMBERS SHOULD NOT BE BILLED ABOVE THEIR COST SHARE FOR EMERGENCY CARE AND FOR NON-EMERGENCY CARE RENDERED BY A NONPARTICIPATING PROVIDER AT A PARTICIPATING FACILITY WHEN: (1) A PARTICIPATING PROVIDER IS UNAVAILABLE, OR (2) THE SERVICES RENDERED ARE UNFORESEEN, OR (3) MEMBER DID NOT CONSENT TO RECEIVING SERVICES BY NONPARTICIPATING PROVIDER.

CATEGORY	INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
TIMELY FILING	**008**	TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
TIMELY FILING	**024**	TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
TIMELY FILING	**025**	TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
TIMELY FILING	**026**	TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
TIMELY FILING	**041**	TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
TIMELY FILING	**043**	TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
TIMELY FILING	**044**	TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
TIMELY FILING	**051**	TIMELY FILING LIMIT 2 YEARS.