

### INELIGIBLE REASON CODE LIST

INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
<b>008</b>	Time limit for filing claims has expired.
<b>024</b>	Time limit for filing claims has expired.
<b>025</b>	Time limit for filing claims has expired.
<b>026</b>	Time limit for filing claims has expired.
<b>041</b>	Time limit for filing claims has expired.
<b>043</b>	Time limit for filing claims has expired.
<b>044</b>	Time limit for filing claims has expired.
<b>051</b>	Timely filing limit 2 years.
<b>01G</b>	A Status 'B' code has been applied. It is bundled into the payment for other services not specified. The participating provider cannot bill you for the disallowed code.
<b>01P</b>	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.
<b>02D</b>	Claim denied based on information provided. Specific requested medical information should be provided for appeal/reconsideration of this claim.
<b>02G</b>	A separate charge is not allowed as it is included in another service. As a non-participating provider, you should not bill the patient for the balance resulting from this coding practice. The patient has been notified.
<b>02P</b>	Payment was reduced because the submitted service exceeds the number of units/visits/day approved on the preauthorization and/or referral on file. Since you are a participating provider, the member is not responsible for these charges.
<b>05D</b>	This claim reviewed at the request of the host plan.
<b>06D</b>	Claim denied. Procedure/treatment has not been deemed proven to be effective.
<b>07H</b>	This charge is not covered. Services related to experimental procedures are excluded under the patient's benefit or policy.
<b>08D</b>	The related claim/service was not identified on this claim.
<b>09D</b>	Rent/purchase guidelines were not met.
<b>10D</b>	Claim denied as the information submitted does not support this length of service.
<b>11D</b>	The referring provider is not eligible to refer the service billed.
<b>14D</b>	This provider was not certified/eligible to be paid for this procedure/service on this date of service.



<b>15D</b>	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
<b>19E</b>	Service requires prior authorization from Carelon Medical Benefits Management. To have your claim considered for payment, please initiate a prior authorization request directly with Carelon at <a href="http://providerportal.com">providerportal.com</a> . The patient is not responsible for this charge.

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22E	Service requires prior authorization from Carelon Medical Benefits Management. To have your claim considered for payment, please initiate a prior authorization request directly with Carelon at <a href="http://providerportal.com">providerportal.com</a> . The patient is not responsible for this charge.
30D	This claim is part of a global fee pricing agreement. Payment has previously been included on a separate claim.
32D	This claim has been denied due to possible error. The claim is under review.
34H	A copy of the current blood gases report is needed before the claim can be considered
36D	Claim was processed in error. Charges are being considered on another claim.
37D	Claim was processed in error. Charges are being considered on another claim.
39D	This claim is a duplicate of a claim that has been processed and paid to the provider directly.
44D	Waiting period for transplant services has not been fulfilled per the member's benefit plan.
44H	A separate charge for venipuncture arterial puncture is not covered
50H	These charges are not covered. The services exceed the maximum number of visits allow for home health care per the member's benefit plan or policy
51D	Provider did not timely file claim per provider's agreement with the plan.
51H	These charges are not covered. The maximum number of surgical procedures in a single surgical session has been exceeded according to the member's benefit plan or policy
52H	Number of days billed exceed approved days. Claim is in review.
53D	Only authorized days are eligible for benefits.
54D	Services were denied because an authorization was approved for an observation stay only
55D	Claim denied because preauthorization is required per member's benefit plan
56D	The services submitted exceed the number of visits previously approved
57D	Prior authorization is required and was not obtained and therefore not covered under the member's benefit plan
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
58D	Claim denied because required pre-authorization is not on file
59D	Provider's request for prior authorization/precertification was denied

<b>59H</b>	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
<b>61H</b>	These charges are not covered. This procedure is one that can only be received once in a patient's lifetime per the member's benefit plan or policy. Our records show that we have already processed a claim for this type of procedure for this patient
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<b>64D</b>	Claim filed after member's benefit plans timely filing period
<b>65D</b>	Claim submitted with incorrect member ID and is being resubmitted by the plan
<b>78D</b>	In order for your claim to be processed, you are required to enroll in the Medicaid program of the home state where the member resides
<b>78H</b>	These charges are not covered. The services exceed the maximum number of units allowed per the member's benefit plan or policy
<b>84D</b>	The DME purchase price has been reduced by prior rental found in history for this same item
<b>86D</b>	DME purchase-only claim submitted, prior rental found in history. No additional payment can be made
<b>92D</b>	Charges billed do not match the associated medical records/documentation received. Services provided by a participating/network provider. Patient is not responsible
<b>94H</b>	Maximum visits for speech therapy have been reached. To request additional visits, we need the referring physician's prescription, initial evaluation, treatment plan and progress notes from start of care thru last visit
<b>95H</b>	Denied based on info provided. X-rays/photos should be provided for appeal/ reconsideration of this claim
<b>96H</b>	Claim denied based on information provided. Entire psychiatric record with the exception of psychotherapy notes should be provided for appeal/reconsideration of this claim
<b>97H</b>	Claim denied based on information provided. Psychiatric assessment/evaluation must be provided for appeal/reconsideration of this claim
<b>98H</b>	Claim denied based on information provided. Psychiatric testing should be provided for appeal/reconsideration of this claim
<b>A03</b>	The service/procedure submitted is only payable once per lifetime. Our records indicate the service was previously performed. For more information, please refer to the Standard and Requirements information on our provider website
<b>A06</b>	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.
<b>A07</b>	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.



<b>A08</b>	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 on our provider website.
<b>A09</b>	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.
<b>A11</b>	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.
<b>A12</b>	The service is not payable in conjunction with another service performed on the same patient at the same time.
<b>A13</b>	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.
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<b>A14</b>	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.
<b>A15</b>	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.
<b>A16</b>	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.
<b>A19</b>	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.
<b>A20</b>	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.
<b>A21</b>	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.
<b>A22</b>	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.



<b>A23</b>	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.
<b>A24</b>	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 Requirements information on our provider website.
<b>A25</b>	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.
<b>A26</b>	The patient's health benefit limits coverage for this service to once a lifetime. As a participating provider, patient cannot be billed for the balance
<b>A27</b>	The patient's health benefit limits coverage for this service to once a lifetime
<b>A28</b>	The patient's health benefits limits coverage for this service to a set number on a single date of service
<b>A29</b>	The patient's health benefit limits coverage for this service to a set number of times within a period of time
<b>A30</b>	The patient's health benefits limits coverage for this service to a set number on a single date of service. As a participating provider, patient cannot be billed for the balance
<b>A31</b>	The patient's health benefits limits coverage for this service to a set number on a single date of service
<b>A32</b>	The patient's health benefit plan limits coverage for this service to a specific place of treatment. As a participating provider, patient cannot be billed for the balance
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<b>A33</b>	The patient's health benefit plan limits coverage for this service to a specific place of treatment
<b>A34</b>	The patient's health plan restricts benefits for this service when billed with a similar service. As a participating provider, patient cannot be billed for the balance
<b>A35</b>	The patient's health plan restricts benefits for this service when billed with a similar service
<b>A36</b>	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
<b>A37</b>	This service/procedure is not payable with the diagnosis billed on the claim
<b>A38</b>	The service/procedure submitted is only payable a limited number of times within a specified time period. As a participating provider you may not bill the member for the balance

<b>A39</b>	The service/procedure submitted is only payable a limited number of times within a specified time period
<b>A40</b>	The procedure code submitted is not payable. Please verify coding to determine whether a more specific code should be billed. As a participating provider, you may not bill the member for the balance
<b>A41</b>	The procedure code submitted is not payable. Please verify coding to determine whether a more specific code should be billed
<b>A42</b>	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.
<b>A43</b>	The units billed exceed the total allowable units. Reimbursement is based on the total allowable units.
<b>AH1</b>	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.
<b>AH2</b>	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.
<b>AH3</b>	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.
<b>AH4</b>	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.
<b>AH5</b>	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.
<b>C04</b>	Based on claim review of the inpatient services, payment is included in the allowance for the primary service. Patient cannot be billed for the disallowed service
<b>C06</b>	Based on claim review of the outpatient services, payment is included in the allowance for the primary services. Patient cannot be billed for the disallowed service.
<b>C08</b>	A separate notification has been sent requesting additional information including medical records and/or itemized bills which is required in order to process this claim.
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<b>E55</b>	Precertification was not obtained from EviCore, service is denied.
<b>E56</b>	Precertification was not obtained from EviCore, service is denied.
<b>G01</b>	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
<b>G03</b>	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.
<b>G04</b>	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.
<b>G05</b>	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.
<b>G06</b>	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.
<b>G07</b>	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.
<b>G08</b>	Services are mutually exclusive. The clinically more intense service has been reimbursed, and the Comparable service is mutually exclusive. As a non-participating provider, you should not bill the patient for the balance resulting from this coding practice. The patient has been notified.
<b>G09</b>	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.
<b>G10</b>	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.
<b>G11</b>	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.
<b>G12</b>	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.

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<b>G13</b>	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.
<b>G14</b>	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.
<b>G15</b>	Per coding conventions, this procedure code / modifier combination is invalid. Please resubmit.
<b>G16</b>	Per coding conventions, this procedure code / modifier combination is invalid. Please resubmit.
<b>G17</b>	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.
<b>G18</b>	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.
<b>G19</b>	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.
<b>G20</b>	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.
<b>G21</b>	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. (PCS modified 9/2013)
<b>G22</b>	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. (PCS modified 9/2013)
<b>G23</b>	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 coding guidelines. As a participating provider, you may not bill the patient for the balance.
<b>G24</b>	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 coding guidelines.
<b>G25</b>	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.
<b>G26</b>	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.
<b>G27</b>	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
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	component has previously been paid. You may not bill the patient for this amount.
<b>G28</b>	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.
<b>G29</b>	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.
<b>G30</b>	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.
<b>G31</b>	Co-surgeon is not covered for this procedure. As a participating provider, you may not bill the patient for this service.
<b>G32</b>	Co-surgeon is not covered for this procedure
<b>G33</b>	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.
<b>G34</b>	The charge for this type of service is included in the initial obstetrical claim and may not be billed separately.

<b>G37</b>	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 <a href="http://www.bcbsil/tx/ok/nm/mt.com/provider">www.bcbsil/tx/ok/nm/mt.com/provider</a> for additional information on claim processing tools and edits used by your corresponding state.
<b>G38</b>	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 <a href="http://www.bcbsil/tx/ok/nm/mt.com/provider">www.bcbsil/tx/ok/nm/mt.com/provider</a> for additional information used by corresponding state.
<b>G39</b>	Durable medical equipment services indicate a rental charge. Previous charges indicate member has purchased this DME item. The patient is responsible for this charge.
<b>G40</b>	Durable medical equipment services indicate a rental charge. Previous charges indicate member has purchased this DME item. The patient is responsible for this charge.
<b>G41</b>	Durable medical equipment services indicate a purchase charge. Previous charges indicate member has purchased this DME item. The patient is responsible for this charge
<b>G42</b>	Durable medical equipment services indicate a purchase charge. Previous charges indicate member has purchased this DME item. The patient is responsible for this charge
<b>G43</b>	The maximum allowance for the DME has been exceeded; as a participating provider, you may not bill the patient for the balance
<b>G45</b>	Durable medical equipment billed exceeds the total number of units allowed. As a participating provider, you may not bill the patient for the balance
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<b>G46</b>	Durable medical equipment charge exceeds the total number of units allowed. The patient is responsible for this charge.
<b>G47</b>	The charges submitted have exceeded the recommended number of supplies for the CPAP/BIPAP item
<b>G48</b>	The charges submitted have exceeded the recommended number of supplies for the CPAP/BIPAP item. Patient is responsible for this charge.
<b>G51</b>	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.
<b>G52</b>	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.
<b>G53</b>	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.
<b>G54</b>	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.

<b>G55</b>	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.
<b>G56</b>	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
<b>G69</b>	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.
<b>G70</b>	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.
<b>G71</b>	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
<b>G72</b>	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.
<b>G73</b>	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.
<b>G74</b>	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.
<b>G75</b>	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.
<b>G76</b>	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.
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<b>G77</b>	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.
<b>G78</b>	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.
<b>G80</b>	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.

<b>G85</b>	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
<b>G86</b>	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
<b>G87</b>	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.
<b>G88</b>	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.
<b>G89</b>	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.
<b>G90</b>	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
<b>G91</b>	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
<b>G93</b>	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.
<b>G94</b>	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
<b>G95</b>	The information submitted on the claim is inconsistent with current coding protocol. The primary procedure code was denied therefore, the related services are not allowed. As a participating provider you may not bill the patient for the disallowed code.
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<b>G96</b>	The information submitted on the claim is inconsistent with current coding protocol. The primary procedure code was denied therefore, the related services are not allowed. As a non-participating provider, you should not bill the patient for the balance resulting from this coding practice. The patient has been notified.
<b>H08</b>	A separate charge for this procedure is not allowed as it is included on this date in another procedure already reviewed for payment.
<b>H15</b>	Benefits for services were not approved during precertification.
<b>H16</b>	Services do not fall within scope of provider license.
<b>H25</b>	Part of the charges submitted on this claim are being processed as a second claim. A separate notice will be sent when we have completed our benefit determination.
<b>H27</b>	Members's primary care physician information is missing or invalid.
<b>H28</b>	Benefits are not available when the services received are provided by an Out of Network Provider.
<b>H44</b>	This claim/service has been denied. Appeal procedures were not followed or provided within the time limit specified by the patient's benefit plan.
<b>H65</b>	Benefits for these services cannot be determined at this time. When records for this group have been properly reconciled, these services will be reconsidered for payment determination.
<b>H73</b>	Based upon the indication that these services are work related, this claim has been denied.
<b>H74</b>	These charges are not covered because the patient has exceeded the number of visits authorized.
<b>H76</b>	These charges are not eligible because they exceed the maximum number of units authorized.
<b>H77</b>	These charges are not covered. The services exceed the maximum number of visits allowed per the member's benefit plan or policy.
<b>H81</b>	These charges cannot be processed until we receive health history information. This information is needed to determine benefits per the member's benefit plan or policy. These charges will be considered when this information is received.
<b>H95</b>	These charges are not covered. These services are subject to prior approval under the member's benefit plan or policy.
<b>H98</b>	Payment for these services has been previously made to the transplant center as part of the transplant payment allowance.
<b>M03</b>	Service 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.
<b>M04</b>	Service(s) not performed or ordered by the primary care physician as required by member's contract. Member is responsible for payment.

<b>NSA</b>	This service is subject to the No Surprises Act (NSA). BCBS{XX} certifies that the Qualifying Payment Amount (QPA) applies as the recognized amount to this service and each QPA was determined in compliance with the NSA. If you wish to initiate a 30-day open negotiation period for purposes of determining the amount of total payment, you may contact us at <a href="http://availability.com">availability.com</a> , {(xxx) xxx-xxxx}, or email <a href="mailto:nsadisputes@bcbsxx.com">nsadisputes@bcbsxx.com</a> to initiate negotiations. If the 30-day negotiation period does not result in agreement, you may initiate the independent dispute resolution process within 4 days after the end of the negotiation period.
<b>INELIGIBLE REASON CODE</b>	<b>PROVIDER CLAIM SUMMARY MESSAGE</b>
<b>PS1</b>	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.
<b>T06</b>	Network provider did not obtain required pre-authorization and/or referral. Therefore, no payment can be made. Member is not responsible for payment of the non-covered charges.
<b>T97</b>	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 <a href="http://www.tdi.texas.gov">www.tdi.texas.gov</a> . Once submitted, please notify <a href="mailto:bcbstx@tx.provider.arbitration@bcbstx.com">bcbstx at tx.provider.arbitration@bcbstx.com</a> .
<b>TXA</b>	Under the Texas law, a member must not be billed above their cost-share for emergency ground ambulance services. Allowed amount was determined using information from the Texas department of Insurance emergency ground ambulance data.
<b>UM4</b>	The member's health plan recommends a review of medical necessity by Caelon Medical Benefits Management before benefits can be approved. Medical records are required.
<b>UM5</b>	The member's health plan recommends a review of medical necessity by Caelon Medical Benefits Management before a benefit decision can be made. Medical records are required.
<b>V01</b>	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.
<b>V02</b>	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.
<b>V07</b>	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.
<b>V08</b>	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.
<b>V09</b>	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.

<b>V10</b>	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.
<b>V11</b>	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.
<b>V12</b>	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.
<b>V13</b>	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.
<b>INELIGIBLE REASON CODE</b>	<b>PROVIDER CLAIM SUMMARY MESSAGE</b>
<b>V14</b>	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.
<b>V15</b>	The service is included in the global surgical package, therefore is not separately reimbursable. The participating provider cannot bill you for the disallowed code.
<b>V16</b>	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.
<b>V17</b>	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.
<b>V18</b>	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.
<b>V19</b>	A separate charge is not allowed as it is included in another service. The Participating Provider cannot bill you for the disallowed code.
<b>V20</b>	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.

<b>V21</b>	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
<b>V22</b>	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.
<b>V23</b>	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.
<b>V24</b>	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.
<b>V25</b>	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.
<b>V26</b>	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.
<b>V29</b>	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.
<b>V30</b>	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
<b>INELIGIBLE REASON CODE</b>	<b>PROVIDER CLAIM SUMMARY MESSAGE</b>
	has been notified.
<b>V31</b>	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.

<b>V32</b>	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.
<b>V33</b>	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.
<b>V34</b>	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 was notified to discuss this matter with the provider if billed for the disallowed service
<b>V35</b>	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.
<b>V36</b>	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.
<b>V37</b>	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.
<b>V38</b>	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.
<b>V41</b>	Services have been unbundled. The information submitted on the claim is inconsistent with current coding protocol. Patient cannot be billed for the disallowed code.
<b>V42</b>	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.
<b>V53</b>	After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. Patient cannot be balanced billed.
<b>V54</b>	After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. As a non-participating provider, you should not bill the patient for the balance resulting from the code billed. The patient has been notified.
<b>V55</b>	After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. Patient cannot be balanced billed for the disallowed code.

INELIGIBLE REASON CODE	PROVIDER CLAIM SUMMARY MESSAGE
<b>V56</b>	After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. As a non-participating provider, you should not bill the patient for the balance resulting from the code billed. The patient has been notified.
<b>V57</b>	After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. Patient cannot be balanced billed for the disallowed code.
<b>V58</b>	After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. As a non-participating provider, you should not bill the patient for the balance resulting from the code billed. The patient has been notified.
<b>V59</b>	After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made patient cannot be balanced billed for the disallowed code.
<b>V60</b>	After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. As a non-participating provider, you should not bill the patient for the balance resulting from the code billed. The patient has been notified.
<b>V61</b>	After review of the claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. Patient cannot be balanced billed for the disallowed code.
<b>V62</b>	After review of claims data, the submitted modifier(s) could not be validated; therefore, payment cannot be made. As a non-participating provider, you should not bill the patient for the balanced resulting from the code billed. The patient has been notified.
<b>V64</b>	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
<b>V65</b>	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.
<b>V66</b>	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.
<b>V67</b>	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.



<b>V68</b>	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.
<b>V69</b>	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.
<b>V72</b>	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.
<b>V73</b>	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.
<b>INELIGIBLE REASON CODE</b>	<b>PROVIDER CLAIM SUMMARY MESSAGE</b>
<b>V74</b>	The level of service for the evaluation and management code submitted is not supported by the claim information received. A more appropriate code has been suggested. The patient cannot be billed for the disallowed code.
<b>V75</b>	The level of service for the evaluation and management code submitted is not supported by the claim information received. A more appropriate code has been suggested. Patient cannot be billed for the disallowed code.