

Ineligible Reason Codes

<u>001- 099:</u>	
001	= Place of treatment required
002	= Patient's name required
003	= Patient's date of birth required
004	= Date of admission required for an inpatient claim
005	= Date of service required
006	= No record of membership
007	= Group stop code in force
008	= Timely filing-end of the year in which the services were received
009	= Member stop code in force
010	= Prior to effective date
011	= On or after termination date
012	= Dependent not listed
013	= Patient name differs from name on file
014	= No spouse coverage
015	= Patient not eligible for benefit-per group
016	= No dependent coverage
017	= Student certification required
018	= Student certification expired
019	= Date of discharge required
020	= Name and address of hospital required
021	= Name and address of physician required
022	= Medicare A & B effective dates required
023	= Time of admission required
024	= Time limit for filing claims - end of the following year
025	= Time limit for filing claims - XX number of months from service date
026	= Time limit for filing claims - XX number of years from service date
027	= Due to pregnancy member is on lay-off. She must contact group for final benefit consideration
028	= Patient not eligible per member - patient ineligible code
029	= Retroactive membership change results in a denial & RFCR
030	= Male spouse not eligible due to member is male
031	= Female spouse not eligible due to member is female
032	= Patient sex differs from patient trailer sex
034	= Bank system processed claim
035	= Blue Cross and/or Blue Shield coverage dropped or member has no Blue Cross and/or Blue Shield coverage
036	= Terminal OB-Group did not approve benefits
037	= Terminal OB date has expired
041	= Time limit for filing claims - XXX number of days from last date of service
043	= Time limit for filing claims - XX months after end of year
044	= Time limit for filing claims - March 31 of the year following the year in which services were provided
047	= Pricing information specific to the patient's type of coverage requested from Par Plan
049*	= Dates of services are prior to effective date of Medicaid Subrogation statute
051	= Time limit for member to file claims is 2 years. However, if services were provided in the last 3 months of any year, apply to the following years filing limit

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058	=	Return claims to the out-of-state provider
059	=	BlueCard Border State Provider has Dual Participation Agreement with Illinois and Home Plan
060	=	BlueCard claim spans the Illinois Provider Participation Agreement Effective Date
		<u>100 – 199:</u>
100	=	Admission is prior to patient's date of birth
101	=	Admission/Bill From date is after patient's expired date
102	=	Discharge/Bill To date is after patient's expired date
103	=	Procedure not indicated on bill/claim
104	=	Anesthesia time not indicated on bill/claim
105	=	Diagnosis not indicated on bill/claim
106	=	Service charge(s) not indicated on bill/claim
107	=	Invalid place of treatment for type of procedure performed
108	=	Invalid procedure for type of diagnosis indicated
109	=	Transmittal record not on file (psyche claim)
110	=	Services after MM/DD/YY disapproved
111	=	Transmittal record not current - update required
112	=	Invalid provider for type of procedure indicated
113	=	Date of accident, injury, medical condition, or treatment date not indicated on the bill
114	=	Invalid procedure for patient's sex type
115	=	Lifetime reserve days billed on Extended Care Facility (ECF)/Skilled Nursing Facility (SNF) claims
116	=	Baby's charges must be separated from mother's claim
119	=	Overage dependent
120	=	Overage dependent - age XX
121	=	Overage dependent - end of month for age
122	=	Overage dependent - end of year in which reach age XX
123	=	Overage student dependent - age XX
124	=	Overage student dependent - end of month for age XX
125	=	Overage student dependent - end of year in which reach age XX
126	=	Overage student dependent
127	=	Patient is an ineligible member or spouse per member/spouse ineligible code
128	=	Duplicate continuous stay. Segment exists for bill to and bill from dates
129	=	This charge is a duplicate of a previously processed claim
130*	=	Ambulance miles required
131	=	This provider is not eligible to bill for these services
132	=	Services prior to start up agreement dates
133	=	Individual or Group premiums not paid. Services after the premium grace period due date are not eligible for benefits
134	=	Services for future dates are not covered
135*	=	Services prior to Blue Chip conversion
136	=	Major Medical coverage only
137	=	Member not covered for these dates of services due to lapse in coverage
139	=	Dependent after XX number of days after last date of attendance not covered
140	=	Group did not approve extension of benefits
141	=	Student dependent not covered after graduation date

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142	=	This charge was processed by the previous health insurance carrier
144	=	Invalid procedure (CPT CODE) for age of patient. Letter to provider requesting verification of code submitted
145	=	Surgical procedure not indicated on claim. Additional information letter sent to provider
146	=	Invalid CPT procedure code (Service referred to Par Plan to correct)
147	=	Additional pricing information requested from Par Plan
148*	=	Claim submitted by Par Plan through ITS/ACES cannot be incremented. PAR Plan contacted
150	=	Contract does not cover this type of outpatient hospital service
151	=	Pro-Component charges cannot be billed on UB-92. Provider instructed to resubmit on HCFA 1500 claim form
152	=	Blue Cross and Major Medical coverage only
153	=	This ambulance service is not covered
		<u>200 – 299:</u>
200	=	Control Plan handles foreign claim.
201	=	Normal newborn charges must be billed on mother's claim.
202	=	Baby's stay over 15-day maximum.
203	=	Normal newborn not covered.
204	=	MD certification required for transsexual surgery.
205	=	Coordinated Home Care (CHC) admission not within days/hour limit of hospital discharge.
206	=	Day psyche admission not within days limit of hospital discharge.
207	=	Night psyche admission not within days limit of hospital discharge
208	=	Cardiac rehab not within months of hospital discharge
209	=	OP alcohol abuse program not within hours/days of hospital discharge
210	=	OP drug abuse program not within hours/days of hospital discharge
211	=	Benefit is self insured through the group
214	=	Student Health offices must verify services
215	=	Medical group approval required
216	=	Group recertification required for this benefit
217	=	Recertification for each confinement/service/XX number of days was not done
218	=	Prior admission did not have same condition required for this service
219	=	Maximum stay for this condition reached
220	=	Follow-up accident handled by control plan
221	=	Cardiac rehab claims handled by control plan
222	=	Benefit processed by control plan
223	=	Repair/replacement - investigate if covered by other insurance
224	=	Replacement - investigate if due to illness/injury
226	=	Routine physical examination not covered
227	=	Physician's charges must be billed separately
228	=	Ineligible - prior admission denied for HCNR
229	=	IV's were not administered for detox
230	=	Admission date was not within XX number of days
231	=	Ambulance service handled by Health Service Incorporated
232	=	Repair/replacement must be billed by hospital
233	=	Repair/replacement not covered for dental appliance or cataract lenses if not a prescription change

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234	=	Repair/replacement must be MD prescribed
235	=	Extended Care Facility (ECF)/Skilled Nursing Facility (SNF) prior admission qualification not met
236	=	Normal newborn not covered because mother is dependent
237	=	Normal newborn not covered because mother is not eligible
238	=	Normal newborn not covered because member was not covered 270 days prior to delivery
239	=	OB not covered because the mother was not eligible for OB
240	=	OB not covered because pregnancy occurred prior to effective date
241	=	Concurrent mental and medical care - only the higher charge is eligible
242	=	Concurrent radiation and medical care-only the higher charge is eligible
243	=	Service's prior admission qualifications not met
244	=	Acupuncture is not eligible for this service
245	=	Admission history exam is not a benefit
246	=	Anesthesia is not covered for this procedure
247	=	Only annual physical exam covered
248	=	Assistant surgeon is not covered for this procedure
249	=	This benefit category is not covered
250	=	This benefit category is not covered for this diagnosis
251	=	This method of chemotherapy administration is not covered
252	=	Concurrent medical for different physician
253	=	Concurrent medical for the same physician
254	=	Congenital surgery not covered for pre-existing condition
255	=	This type of congenital surgery/service not covered
256	=	Cosmetic services/surgery due to an illness/accident occurring prior to effective date
257	=	Cosmetic services/surgery not due to an accident or not related to congenital condition for a patient of age 12 or under
258	=	Cosmetic services/surgery not due to accident/or reconstruction due to malignancy or not related to congenital condition
259	=	This type of cosmetic service/surgery not covered
260	=	Cosmetic services/surgery not due to an accident
261	=	Day psyche not performed for a mental condition
262	=	Day psyche not performed by Participating Provider
269	=	This service is not covered for this diagnosis
270	=	Extended Care Facility (ECF)/Skilled Nursing Facility (SNF) admission is not covered for an OB or mental condition
271	=	Extended Care Facility (ECF)/Skilled Nursing Facility (SNF) admission is not covered for a TB condition
272	=	This service is not a covered benefit unless it is MD certified
273	=	Services are not covered by contract for this type of provider
274	=	Only employment physical exams are covered
275	=	Family counseling is not covered unless the patient is present
276	=	Foreign claims are not covered by this contract
277	=	This method of anesthesia is not covered
278	=	Hair transplant is not a benefit
279	=	Inpatient dental admission requires MD certification
280	=	Procedure code is not valid for place of treatment
281	=	This service needs an EOMB to process

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282	=	Night psyche not performed for a mental condition
283	=	Night psyche not performed by a Participating Provider
284	=	Procedure not a corporately covered procedure
285	=	Services due to OB condition are not covered
286	=	OB is not covered for single coverage
287	=	OB for normal delivery is not a benefit
288	=	OB for other than elective abortion is not a benefit
289	=	OB waiting period not met
290	=	Onset date prior to member's effective date
291	=	Onset date prior to patient's effective date
292	=	OP surgery follow up is not a benefit
293	=	Patient is not eligible for OB benefits
294	=	Patient has exceeded the age limit for this service
295	=	Services are not covered by the contract for this place of treatment
296	=	Only pre-marital physical exams are covered
297	=	Pre and post natal care is not a benefit
298	=	Routine exam is not a benefit
299	=	This service is not a benefit of the contract (provision is not covered)
		<u>300 – 399:</u>
300	=	Repair/replacement: not covered because not due to damage
301	=	Repair/replacement: not covered because not due to growth
302	=	Repair/replacement: not covered because condition does not warrant it
303	=	Replacement: not covered due to accident
304	=	Same Provider: billing surgery & anesthesia. Anesthesia not covered
305	=	Same Provider: billing surgery & assistant surgery. Assistant surgery not covered
306	=	Same Provider: billing chemotherapy and medical care. Medical care not covered
307	=	Same provider: billing medical and consultation. Consultation not covered
308	=	Same provider: billing surgery and consultation. Consultation not covered
309	=	Same provider: billing Electroshock Therapy (EST) and EST anesthesia. EST anesthesia not covered
310	=	Same provider: billing surgery, anesthesia, and assistant surgery. Anesthesia and assistant surgery not covered
311	=	Same Provider: billing IP medical and radiation therapy. The medical visit not covered
312	=	Same Provider: billing chemotherapy and medical. The medical is not covered
313	=	Same Provider: billing mental and medical care. The medical care is not covered
314	=	Same Provider: billing the delivery normal newborn and/or anesthesia. The normal newborn and anesthesia are not covered
315	=	Same Provider: billing the delivery and prenatal care. The prenatal care is not covered
316	=	Only school physical exams are covered
317	=	Surgery date is not within service dates
318	=	Service in a student health facility are not a benefit
319	=	Only substance abuse physical exams are covered
320	=	Supplemental accident care is not a benefit
321	=	Transsexual surgery/service are not a benefit
322	=	Transsexual surgery/service are not a benefit unless MD certified

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323	=	Hospital certification required for a private room
324	=	This procedure is not covered by this contract
325	=	Patient's date of birth is prior to member's effective date
326	=	Patient must be hospitalized a minimum of XXX days before benefits can begin
327	=	MD certification for private duty nursing care required
328	=	MD certification for durable medical equipment required
329	=	MD certification for ambulance required
330	=	MD certification - all others
331	=	Services not within XX days
332	=	Facility not approved for cardiac rehabilitation
333	=	Outpatient Care Report (OPCR) billed within an Inpatient Care Report (IPCR) stay
334	=	Experimental procedure not covered
335	=	Interval days exceed treatment time factor
336	=	Patient not eligible to receive treatment for alcoholism
337	=	Patient not eligible to receive treatment for drug abuse
338	=	Pre-admission review obtained but not approved
339	=	Pre-admission review was not obtained
340	=	Emergency services beyond hour limit
341	=	Pre-existing waiting period not met. Claim under investigation for pre-existing and pre-existing questionnaire sent to member, professional provider, or facility as determined by operator.
342	=	Pre-existing expense free waiting period not met. Claim under investigation for pre-existing. Pre-existing questionnaire to member, professional provider, or facility as determined by operator.
343	=	This hospital claim needs Medicare's paid amount
344	=	MD certification required for MOPS procedure performed inpatient
345	=	This procedure not covered by your contract for organ transplant
346	=	Medical/surgical advisor was not contacted prior to treatment
347	=	Medical/surgical advisor contacted but did not approve services/treatment
348	=	Room and board charges ineligible for Friday and Saturday when patient admitted on weekend
349	=	All services ineligible when patient admitted on the weekend
350	=	All room and board charges for entire stay ineligible when patient admitted on Friday/Saturday
351	=	All services for entire stay ineligible when patient admitted on the weekend
352	=	Room and board charges not eligible for Saturday/Sunday when patient admitted on Friday/Saturday
353	=	Date of surgery required to process claim
354	=	Itemized charge breakdown per day required
355	=	Medical necessity denial - Inpatient Study (IPS)
356	=	Medical necessity denial - HCNR
357	=	Medical necessity denial - Excessive passes
358	=	Medical necessity denial - Length of stay
359	=	Round trip ambulance fee not covered when admitting provider can perform the service
360	=	Medical records required
361	=	Provider hold flag review of service determined the item to be ineligible
362	=	All charges for Friday/Saturday preceding Monday discharge ineligible unless MD certified
363	=	Member is not covered under the additional transplant coverage program
364	=	Medical department has approved the facility, but not the actual organ transplant
365	=	Medical department has not approved the facility, but has approved the organ transplant
366	=	Medical department has not approved the facility or the organ transplant

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367	=	Service not covered eligibility criteria for additional transplant not met
368	=	Mandatory Additional Surgical Opinion Program (MASOP) required for this procedure
369	=	Room and board charges not covered for MOPS inpatient
370	=	Bereavement counseling must begin within XXX days of immediate family member death
371	=	First days room & board charges ineligible when patient admitted on a weekend unless MD certified
373	=	Coordinated Home Care (CHC) must be recertified every 15 days
374	=	Extended Care Facility (ECF) must be recertified every 30 days
376	=	Benefit eligible only if performed as part of an approved hospice program
377	=	Benefit eligible only if approved by Employee Assistance Program (EAP) coordinator
378	=	Services covered only when billed with OP psych or home dialysis
379	=	This service covered only for preschool immunizations
380	=	This service covered only when MD certified or ICU not available
381	=	This service covered only "from age" as specified in member's policy
382	=	This service covered only "to age" as specified in member's policy
383	=	Covered only for ear exam by MD, test ordered by MD, or consultation with MD who performed the exam
384	=	This service covered only when Blue Shield days are available for mental care
385	=	This service covered only when Blue Cross inpatient days are available
386	=	All services for Friday, Saturday and Sunday not covered when patient is admitted on the weekend
390	=	Same provider billing surgery and anesthesia. The anesthesia charges over the usual charge for surgery are not covered
391	=	Benefits are not provided for services obtained from Non-Participating Providers
392	=	This benefit payable only if within 1 month of related surgery or inpatient admission
393	=	This benefit payable only if by same MD that delivered the child
394	=	Pre-existing waiting period has not been met and the services provided were for a pre-existing condition.
395	=	Pre-existing expense free waiting period has not been met and the services provided were for a pre-existing condition
396	=	Same provider billing delivery, normal newborn and anesthesia. The normal newborn care not covered
397	=	Same provider billing delivery, normal newborn and anesthesia. The anesthesia is not covered
398	=	Additional information request to provider requesting room and board charges
399	=	The whole claim provision for this claim is not covered
		<u>400 – 499:</u>
400	=	The maximum benefit available for this service has been paid
401	=	Charge exceeds average semi-private room rate
402	=	Charge exceeds average semi-private plus an additional \$ amount
403	=	Charge exceeds exception schedule allowance
404	=	Charge exceeds the flat rate
405	=	Charge exceeds the flat rate plus an additional \$ amount
406	=	Charge exceeds most common semi-private room rate
407	=	Charge exceeds most common semi-private room rate plus an additional \$ amount
408	=	Charge exceeds Medicare's reasonable amount
409	=	Charge exceeds payment factoring allowance
410	=	Charge exceeds scheduled allowance

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411	= Charge exceeds usual and customary
412	= Charge exceeds usual
413	= Charge exceeds psychiatric global billing parameters
414	= Charge exceeds a percent of average semi-private room rate
415	= Charge exceeds a percent of billed amount
416	= Charge exceeds a percent of most common semi-private room rate
417	= Charge exceeds a percent of the usual and customary
418	= Charge exceeds a percent of usual
419	= Indemnity schedule allowance is zero dollars.
420	= Additional pricing information requested (e.g., Operative Report).
421	= Charge exceeds the Medicare Part A deductible amount.
422	= Charge exceeds Medicare coinsurance.
423	= Charge exceeds the daily lifetime reserve co-payment amount. Since the patient elected to use 'lifetime reserve days', charges in excess of the lifetime reserve co-payment amount may be payable by Medicare Part A.
424	= Medicare paid this amount.
425	= This amount is over DRG.
426	= Additional Medicare information requested, i.e., billing more than 30 days of Medicare insurance.
427	= The Maximum Cost Containment Payment (CCP) benefit available for this service has been met.
428	= Maximum Medicare coinsurance days have been met/exceeded
429	= Maximum Medicare lifetime reserve days have been met/exceeded.
430	= Charge exceeds flat rate plus % of Average Semi-Private (ASP) room rate.
431	= Charge exceeds flat rate plus % of Most Common Semi-Private (MCSP) room rate.
432	= Medical Department has not approved over maximum amount.
433	= Different substance abuse course of treatment maximum met.
434	= Group determined maximum has been met.
435	= Group determined additional benefits not available for this maximum.
437	= RDG (DRG) service line added for balancing of a claim when DRG is greater than amount billed.
438	= Maximum benefit for Coordinated Home Care (CHC) has been met/paid.
439	= Charges exceed allowance payable.
440	= Physical therapy maximum reached. Therapy not renewable because it was not received immediately following surgery for the same condition or injury.
441	= Extended Care Facility (ECF) days paid by Medicare.
442	= Extended Care Facility (ECF) supplemental days exhausted.
443	= Concurrent medical with surgery over U&C when surgical charge has been paid in full.
451	= Charges exceed MCNP schedule of allowances. Non-Participating Provider. Patient responsible for charges over the allowance.
452	= Charges exceed MCNP schedule of allowances. Services were provided by a participating MCNP provider. Patient is not responsible for charges over the allowance.
453	= Charges exceed Medicare's limiting charge.
454	= Charges exceed maximum allowance – Non-Participating Behavioral Health Network provider; patient responsible for charges over the allowance.
459	= Charge exceeds Healthchoice of Connecticut's maximum allowance.
460	= Charge exceeds Healthchoice of Connecticut's negotiated rate. Patient not responsible for charges over the negotiated rate (applies to inpatient and outpatient hospital charges).

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473	= Charges exceed the daily lifetime reserve co-payment amount. Since the patient elected not to use 'lifetime reserve days', charges over the lifetime reserve co-payment amount are the patient's responsibility.
475	= Charges exceed HIAA schedule of allowances. Services were provided by a Non- Participating Provider. Patient is responsible for charges that exceed the HIAA allowance.
478	= Solid organ transplant claim: charges exceed negotiated global or all-inclusive payment for the transplant services. Provider participates in the Blue Quality Centers for Transplant (BQCT) network. The patient cannot be billed for this amount.
479	= Solid organ transplant claim: the charges billed were included in the global or all-inclusive payment already made. Provider participates in the Blue Quality Centers for Transplant (BQCT) network. The patient cannot be billed for this amount.
486*	= National Health Service (NHS) advisor contacted, portion of stay exceeds approved length.
487*	= National Health Service (NHS) advisor was contacted but did not approve treatment/services.
488*	= National Health Service (NHS) advisor was not contacted prior to treatment.
489*	= National Health Service (NHS) was not contacted in a timely manner, i.e. late notification.
494	= Charges exceed private room rate.
496	= Physical therapy maximum has been met. Additional information will be requested from your provider. You will be notified of the outcome.
497	= Invalid Provider for type of procedure indicated (PPO)
498	= Invalid Provider for type of procedure indicated (Non PPO)
	<u>500 – 599:</u>
500	= Continuous stay dates overlapping. Out of sequence with continuous stay trailer. Provider contacted for additional information.
501	= Control plan must review claim for organ transplant before benefit can be determined.
503	= Charges exceed PPO allowance.
504	= L.P.N. not covered since R.N. was available for this service.
505	= Charges over U&C and PPO allowance not covered.
506	= Pre-natal charges must be rolled into delivery charge.
507	= Service not eligible - Failed to meet group guidelines.
508	= Investigation to determine if staff MD available (Assuming yes - no only if questionnaire returned).
509	= Catastrophic - Medical group did not approve.
510	= Medical group did not approve (all other).
511	= Late discharge not authorized.
513	= This type of physical exam is not covered by contract.
514	= Self inflicted injury not covered.
515	= Durable medical equipment not covered since service not given for oxygen.
516	= Out-of-area non-emergency accident/medical care.
517	= Service not covered since condition was not for an ectopic pregnancy.
518	= Service was not covered since patient was not disabled.
519	= Provision covered only if prescribed as a result of an accident or injury.
520	= Emergency room and related services not covered because they're not related to an accident/injury or severe medical emergency.
521	= Infertility services/treatment not covered.

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522	=	Newborn services not covered because baby was not enrolled 30 days prior to birth or 10 days after birth.
523	=	Suicide: Additional information required from the provider to determine if accident/injury was self inflicted.
524	=	OB services not covered because patient did not have continuous coverage under this plan up to time of delivery.
525	=	Treatment for this service is covered only if treatment commenced within 30 days after the date of the accident.
526	=	Obesity not covered unless exogenous with a medical complication.
527	=	Facility not approved for substance abuse.
528	=	Extended Care Facility (ECF)/Skilled Nursing Facility (SNF) admission for alcohol, a drug or TB condition not covered.
529	=	Pre-admission review: Review obtained, however, portion of the stay not approved by advisor.
530	=	Transsexual surgery and related psychiatric care not covered.
531	=	Immunizations related to travel not covered (e.g., going to a foreign country).
532	=	Services are not covered unless treatment is for follow-up accident care.
533	=	Medical emergency did not meet group guidelines.
534	=	Service for follow up care not covered because the initial treatment for accident care was not within the time limit.
535	=	Follow-up chemotherapy visit was not within XX days of last chemotherapy treatment.
536	=	Physical therapy treatment was not within XXX days of surgery or hospital discharge.
537	=	Service not covered because the condition was not due to bacterial infection or an accident.
538	=	Service not covered because the condition was not due to disease or injury.
539	=	Chiropractor services limited to x-rays of the spine.
540	=	Only surface ambulance services are covered.
541	=	Only air ambulance services are covered.
542	=	Service not covered since illness/injury occurred prior to effective date and the waiting period was not met.
543	=	Pre-admission review: Review obtained but not approved. Room and board charges for entire stay not covered.
544	=	Room and board charges not eligible for a non-emergency surgical admission, when pre-admission testing wasn't done.
546	=	Service covered only when related to surgery.
547	=	Social Worker services covered only when under the direction of a physician.
548	=	Social Worker services covered only if claim submitted with group approval and special form is attached.
549	=	Home health aide is not covered as part of the CHC program.
550	=	This service from this provider covered only if related to a covered inpatient surgery or outpatient dislocation/fracture.
551	=	This service from this provider covered only if related to a covered inpatient surgery.
552	=	Medical social worker services covered only if specific group guidelines are met.
553	=	This service is covered only if related to an accident.
554	=	Charges Eligible Under "Workers' Compensation" not covered.
555	=	Charges Eligible Under "Reimbursement" not covered.
556	=	Charges Eligible Under "Workers' Compensation" and "Reimbursement" not covered.
557	=	Charges Eligible Under "Workers' Compensation" and "Medicare" not covered.

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558	= Charges Eligible Under “Reimbursement” And “Medicare” not covered.
559	= Charges Eligible Under “Workers’ Compensation, Reimbursement, and Medicare” not covered.
560	= Medicare’s Payment Estimated – Charges not covered.
561	= Advisor contacted, however, portion of stay exceeds length approved.
562	= Advisor not contacted and portion of stay exceeds contract limit.
564	= Medicare B deductible not covered.
565	= Charges not covered when denied by Medicare.
566	= Rental charge exceeds purchase price of the Durable Medical equipment or cost or purchase has been paid on a prior claim.
567	= Only school physical exams for first, fifth, seventh grade, high school, and required sports are covered.
568	= In-hospital services provided by Non-Participating Providers covered only if related to emergency accident/medical care.
569	= Medical/Surgical advisor not contacted prior to receiving treatment for a psych/substance abuse condition.
570	= Medical/Surgical advisor contacted but course of treatment for a psych/substance abuse condition was not approved.
571	= Patient must be covered by Policy for “XX” number of days before this service is eligible for benefits.
572	= Medical/Surgical advisor did not approve admission. First day room and board charges denied.
573	= Condition not covered for this provider type.
574	= Services for the condition of mental, drug/alcohol abuse are handled by another insurance carrier.
575	= Charges for prenatal are covered only up to U&C of the delivery charge.
576	= Services covered only if performed or received by a PPO provider.
577	= Benefit payable only when provided as part of a total physical therapy program.
579	= Benefit covered under the extended Mental Health coverage.
580	= Benefit covered only if provided or ordered by Primary Care Physician or Medical Group.
583	= Services not covered if diagnosis/treatment is for the following conditions: infertility, maternity, mental/substance abuse.
584	= Services not covered if diagnosis/treatment is for the following conditions: infertility, mental/substance abuse.
585	= Services not covered if diagnosis/treatment is for the following conditions: Mental, drug abuse, or alcohol abuse.
586	= Services not covered if diagnosis/treatment is for substance abuse.
588	= Charges billed by hospital as non-covered on UB-92.
589	= Approval/certification from mental health advisor not obtained prior to receiving treatment for mental health/substance abuse conditions.
590	= Benefit covered Out-of-Network only if treatment is provided by a psychologist or psychiatrist.
592	= Approval/certification from mental health advisor obtained prior to receiving treatment for mental health/substance abuse condition; however, portion of the stay was not approved.
593	= MSA did not approve DME rental or purchase.
594	= Vision care services are handled by an outside vendor.
595	= Treatment for emergency care outside the United States is covered only if treatment was provided within the first 60 days of the trip.
596	= Member has not responded to modified reimbursement questionnaire. Benefits for eligible services are not available until a response to the questionnaire has been received.
598	= Medicare denied service because of insufficient claim information; service cannot be considered for benefits if denied by Medicare.

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Updated: 10/12/2011

Ineligible Reason Codes

599	= Medicare denied service as a duplicate of a previously submitted claim; need Medicare paid amount to process.
	<u>600 – 699:</u>
601	= Cosmetic: Procedure not covered per contract.
602	= Congenital: Procedure not covered per contract.
605	= Congenital: Not due to an accident.
606	= Cosmetic: Condition must be due to accident which occurred while covered under the Plan and treatment must begin within 6 months of the accident date.
608	= Congenital: Accident prior to coverage date.
610	= Cosmetic: Not due to accident, scars, tumors, or disease.
611	= Congenital: Not due to accident, scars, tumors, or diseases.
613	= Cosmetic: Accident or scars, tumors or diseases prior to coverage date and not congenital anomaly/deformity.
614	= Congenital: Accident or scars, tumors or disease prior to coverage .
616	= Cosmetic: Accident prior to effective date and not MD certified.
617	= Congenital: Accident prior to effective date and not MD certified.
619	= Cosmetic: Accident prior to coverage or not due to scars, tumors or disease and not congenital anomaly/deformity
620	= Congenital: Accident prior to coverage or not due to scars, tumors, or disease.
623	= Congenital: Deformities evidenced in infancy are covered.
625	= Cosmetic: Condition must be due to accident, or repair of congenital defect, or disease/surgery of functional body part occurring on or after member's effective date.
626	= Congenital: Surgery over age limit. Patient is not covered.
627	= Cosmetic: Condition must be due to accident and treatment is within 6 months or restoration/correction of functional body part altered because of disease.
629	= Cosmetic: Condition not MD certified or not due to an accident, scars, tumors, disease, or to correct a congenital deformity.
630	= Congenital: Surgery covered only if due to disease, injury, or birth defect.
631	= Cosmetic: Surgery covered only if due to functional congenital anomalies, injury, or scars. Mammoplasty for beautification purposes not covered.
632	= Cosmetic: Surgery covered only if due to congenital defects, injury, scars, or disease that occurred on or after the policy effective date.
634	= Congenital or developmental anomalies are covered only if a second opinion rendered by a medical doctor chosen by the insurance carrier indicated that treatment is medically necessary.
638	= Cosmetic: Condition not due to accident scars, tumors, disease, or congenital deformity or initial hair transplant not covered.
643	= Congenital: Surgery covered only if needed to correct a birth defect in a child to restore bodily function.
661	= Cosmetic: Surgery covered if due to congenital defects or accidental injuries which occurred while covered under the plan.
667	= Billing provider not compatible with performing provider
671	= Cosmetic: Surgery covered only to restore/improve impaired bodily function due to and accident and treatment began within one year of injury date; or to replace tissue due to disease.
672	= Cosmetic: Surgery covered if due to an injury that occurred on or after policy effective date and treatment began within 90 days of injury date.

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Ineligible Reason Codes

673	=	Congenital: Surgery covered only if child was born on or after mother's effective date
674	=	Congenital: Surgery covered for treatment of birth deformities that occurred on or after member's effective date.
681	=	Services received/performed by a non-network provider are not covered.
682	=	Claim denied due to subrogation rights.
686	=	CPT/HCPCS code submitted can not be used to determine benefits.
690	=	Services for the condition of chemical dependency and substance abuse are handled by another insurance carrier/vendor.
691	=	Services for the condition of mental health are handled by another insurance carrier.
		<u>700 – 799; 888:</u>
700	=	Adjustment: Credit only - Reason unknown.
701	=	Adjustment: Stat credit - Reason unknown.
702	=	Adjustment: void claim due to returned dollars.
711	=	Benefits are not provided for expenses that the insured has no legal obligation to pay as determined by Medicare.
713	=	Eye glasses and contact lenses covered only following cataract surgery or if needed as a result of an accident/injury which occurred while covered under the Plan
714	=	Inpatient routine pap smears are not covered.
715	=	Routine ultrasounds/sonograms performed during pregnancy are not covered.
716	=	Medical Advisor did not approve MOPS procedure performed inpatient.
717	=	Acupuncture services when used in lieu of anesthesia are covered only if performed by an M.D.
718	=	Approval/Certification from Mental Health Advisor not obtained prior to receiving outpatient treatment for substance abuse conditions.
719	=	Outpatient focus procedure performed inpatient. Approval from Medical/Surgical Advisor not obtained. Therefore, room and board charges for the entire stay are not covered.
720	=	Only normal newborn services are covered for grandchildren.
721	=	Normal newborn services are not covered when mother's OB waiting period has not been met
722	=	Normal newborn services for grandchildren are covered only in cases of ectopic pregnancy.
723	=	Appliances/post surgery adjustments provided for the treatment of TMJ are not covered.
724	=	Charges paid by other carrier are not eligible for benefits.
725	=	Length of stay exceeds the days approved by the Utilization Management Department. Letter sent to hospital requesting the claim can be re-billed to reflect the hospital charges for only the days approved.
726	=	Approval/certification from Mental Health Advisor not obtained prior to receiving treatment for mental health/substance abuse conditions; therefore the maximum benefits available for this service has been met.
727	=	Replacement of prosthetic appliance covered for dependent children up to the age limit as specified in member's policy.
730	=	Medicare Part A deductible not covered when patient receives non-emergency services from a hospital that does not participate in the MED-Select Network.
731	=	Abortion for dependent children not covered if provided out of network.
732	=	Treatment for TMJ limited to surgical care only.
734	=	Charges Submitted by Primary Care Physician/Medical Group for laboratory services not included in the exempted lab test listing are not covered. Patient cannot be balance billed for these services.

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Ineligible Reason Codes

740	= Approval/certification from mental health advisor not obtained prior to receiving treatment for substance abuse conditions.
742	= MSA did not approve this portion of the patient's stay. Our Medical Department determined that this portion of the stay was not medically necessary. Therefore, room charges incurred for the non-approved days are not covered. Since the patient's health plan is PPO or PPO Plus, and the provider participates in Blue Cross Blue Shield's PPO network, the member is not responsible for payment of the non-covered room charges.
743	= MSA did not approve this portion of the patient's stay. Our Medical Department determined that this portion of the stay was not medically necessary. Therefore, room charges incurred for the non-approved days are not covered. Since the patient's health plan is PPO or PPO Plus, and the provider is <u>not</u> a member of Blue Cross Blue Shield's PPO network, the member is responsible for payment of the non-covered room charges
744	= MSA did not approve this portion of the patient's stay. Our Medical Department determined that this portion of the stay was not medically necessary. Therefore, room charges incurred for the non-approved days are not covered. Since the patient's health plan is <u>not</u> PPO or PPO Plus, the member is responsible for payment of the non-covered room charges
745	= Medical policy review determined that the services provided are not covered based on corporate medical policy criteria.
746	= HIPAA compliant group - Pre-existing condition waiting period not met. Claims under investigation for Pre-existing, Pre-existing questionnaire issued to member with request for copy of certificate of creditable coverage.
747	= HIPAA compliant group - Pre-Existing condition waiting period not met. Claims under investigation for Pre-Existing, request to member for a copy of certificate of creditable coverage.
748	= (Updated 6/23/99) HIPAA compliant: pre-existing waiting period not met. Claim under investigation for pre-existing and questionnaire to member, professional provider, or facility by operator.
749	= HIPAA compliant group - Pre-existing condition waiting period not met. Services provided were for a Pre-existing condition, therefore benefits are unavailable at this time.
750	= Services related to the treatment of a Maternity condition are handled by another insurance carrier or outside vendor.
751	= Mental Health/Substance Abuse care requires pre-certification through outside vendor. Benefit payment denied because Behavioral Health Advisor was not contacted prior to receiving treatment.
752	= Mental Health/Substance Abuse care requires certification/approval through outside. Vendor Benefit payment denied because Behavioral Health Advisor was contacted but did not approve the treatment received.
754	= Certification/approval is required from mental health advisor for the treatment of mental health or substance abuse conditions. Benefit payment denied because mental health advisor was contacted but did not approve the treatment received.
757	= Benefits are not available for out-of-network or self-referred care for services related to the treatment of infertility.
759	= Assistant Surgeon charges are not covered when performed by this type of health care provider.
760	= (For Local 25, Group #P10025 only) Labor Group denies claims for the provider to submit a HCFA 1500/UB-92 to UHS at 1634 W. Polk St., Chicago, IL 60612
763	= The diagnosis is inconsistent with the patients age.
767	= Charges submitted are the responsibility of the behavioral health vendor, please have the provider bill them directly.
779	= The medical records do not substantiate or support the medical necessity for the services provided.

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Ineligible Reason Codes

780	=	The medical records do not substantiate or support the medical necessity for the services provided.
785	=	Accommodative foot orthotics is considered not medically necessary as they do not address structural or functional abnormalities, they are primarily for comfort, and or they are OTC items (w/ or w/out
786	=	Accommodative foot orthotics is considered not medically necessary as they do not address structural or functional abnormalities, they are primarily for comfort, and or they are OTC items (w/ or w/out
797	=	Medical records and previous decision reviewed. Maintain denial.
798	=	Medical records and previous decision reviewed. Maintain denial.
		<u>800 – 899</u>
801	=	Services requested for reimbursement do not match the services documented in the submitted medical record of the documentation submitted does not substantiate the service(s) requested for reimbursement
802	=	Services requested for reimbursement do not match the services documented in the submitted medical record of the documentation submitted does not substantiate the service(s) requested for reimbursement
826	=	HCPSC Code is not valid with NDC (National Drug Code).
827	=	NDC (National Drug Code) is invalid for service date.
828	=	NDC (National Drug Code) is required to price service line.
829	=	NDC (National Drug Code) unit exceeds threshold.
830	=	Medical necessity cannot be established. (Participating Provider)
831	=	Medical necessity cannot be established. (Non-Participating Provider)
832	=	Services determined not medial necessary
		<u>The following ineligibles are operator entered:</u>
901	=	No response from provider to our request for additional information.
902	=	No response from member to our request for additional information.
914	=	Charges applied toward patient's coinsurance share. (Used as needed in order to manually calculate and apply the appropriate coinsurance amount for this claim.)
919	=	Medical and office visit records are being requested to determine medical necessity of these services.
920	=	Services have been reviewed and medical necessity has not been established, therefore this service is not covered under your Medical Plan.
923	=	This claim is being investigated for third party liability coverage, per your plan's subrogation requirements.
925	=	Charges applied toward health care plan co-payment (used as needed in order to manually calculate and apply the appropriate co-payments for this claim).
926	=	The diagnosis is an exclusion rider assigned by Underwriting.
932	=	Billed amount greater than allowed amount. Non-contracting provider, patient is responsible for charges over allowed amount.
936	=	The availability of benefits for the requested procedure(s)/service(s) was reviewed by the account or the account's third party utilization vendor, and it was determined that medical necessity was not established. Therefore, there are no benefits available under the member's health plan.
951	=	Charge exceeds the multiple surgery priced amount for this service. Services provided by a Participating/Network Provider; patient is not responsible for charges over the priced amount.
952	=	Charge exceeds the multiple surgery priced amount for this service. Services provided by a Non-Participating Provider; patient is responsible for charges over the priced amount.
938		Rental charge exceeds purchase price of the durable medical equipment or cost for purchase has been paid on a prior claim. - Member is responsible.

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Ineligible Reason Codes

943	Additional information is requested from the member. If no response is received within 45 days of this notice, no further notice will be given and benefits will be considered denied.
944	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.
947	Charges exceed allowable benefit.
948	The unlisted CPT/HCPCS code submitted cannot be used to determine benefits when a current CPT/HCPCS code is available.
	<i>END OF OPERATOR ENTERED INELIGIBLE CODES</i>
	<u>Alphabetic Ineligible Reason Codes:</u>
LCH*	= Late charge billed on the UB-92 form. The operator has been instructed to adjust the original claim to include this charge. (No EOB or provider claim summary is created for this claim).
LCI*	= Inpatient late charge bill, no original claim on file.
	<u>The following codes can only be used in processing Labor Fund claims:</u>
C03	= This service cannot be processed until charges are filed with other insurance carrier
C33	= Subscriber has not responded to request for other coverage Information.
C35	= Provider has indicated there is other coverage. Our records do not indicate there is other coverage. This service cannot be processed until additional information has been received.
F01	= The claim submitted has been denied for payment by the Labor Fund as the payment information requested from the subscriber's other identified insurance carrier was not submitted.
F02	= The claim submitted has been denied by the Labor Fund as the subscriber's lifetime maximum allowable amount has been met.
F03	= The claim submitted has been denied for payment by the Labor Fund as the subscriber has not complied with the requirements of the other identified insurance company.
F04	= The claim submitted must be re-billed. Hospital charges that reflect the approved days and hospital charges that reflect the non-approved days must be billed on separate claim forms.
F05*	= Charges submitted on prior claim less than 30 days ago. Original claim is in review with the Fund's claim department.
F06	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested a copy of the other carrier's explanation of benefits.
F07	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested an accident/injury questionnaire.
F08	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested a workmen's compensation questionnaire.
F09	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested a claim form.
F10	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested physical therapy notes.
F11	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested eligibility information.
F12	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested a marriage certificate.

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Ineligible Reason Codes

F13	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested student certification.
F14	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested a birth certificate.
F15	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested employer contributions.
F16	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested medical records.
F17	= This claim is being denied because the member did not respond to a request for additional information. The member's Labor Fund has requested third party liability information.
SAJ	= Suspected possible adjustment of a claim previously finalized by the Fund.
SDU	= Suspected duplicate charge (for use in processing Labor Fund claims).
SMA	= Charge exceeds the maximum allowance for the service rendered.
	<u>The codes below are specific to GMIS (i.e. Claim Check) Processing Logic:</u>
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 the balance resulting from this coding practice.
G02	= Charge is an exact duplicate of a charge already processed on this claim. Coding practice utilized by Non-Participating Provider is inconsistent with current coding protocol. Patient was notified to discuss this matter with the provider if billed for the balance resulting from this coding practice.
G03	= This service is incidental to primary procedure code. Payment is included in allowance for primary service. 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.
G04	= This service is incidental to primary procedure code. Payment is included in allowance for primary service. Coding practice utilized by this Non-Participating Provider is inconsistent with current coding protocol. Patient notified to discuss this matter with the provider if billed for the balance resulting from this coding practice.
G05	= Services have been unbundled. Separately billed services have been re-bundled under a single code, as they are components of that same service. 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.
G06	= Services have been unbundled. Separately billed services have been re-bundled under a single code, as they are components of that same service. Coding practice utilized by Non-Participating Provider is inconsistent with current coding protocol. Patient notified to discuss with the provider if billed for the balance resulting from this coding practice.
G07	= Services are mutually exclusive. The clinically more intense service has been reimbursed and the comparable service is 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.
G08	= Services are mutually exclusive. The clinically more intense service has been reimbursed and the comparable service is mutually exclusive. Coding practice utilized by this Non-Participating Provider is inconsistent with current coding protocol. Patient notified to discuss this matter with the provider if billed for the balance resulting from this coding practice.
G10	= Non-Participating post-operative.

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Ineligible Reason Codes

G11	=	Participating pre-operative.
G12	=	Non-Participating pre-operative.
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.
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. Patient notified to discuss this matter with provider if billed for the balance resulting from this coding practice.
G15	=	This procedure is not recommended for reimbursement.
G16	=	This procedure code/modifier combination is invalid.
G17	=	The code submitted is inappropriate for the patient's gender. (PPO Provider)
G18	=	The code submitted is inappropriate for the patient's gender. (Non PPO Provider)
G19	=	The code submitted is inappropriate for the patient's age. (PPO Provider)
G20	=	The code submitted is inappropriate for the patient's age. (Non PPO Provider)
T43	=	Charges exceed the priced amount for this service. Services provided by a Non-Participating Provider. Patient is responsible for charges over the priced amount.
T58	=	Charge exceeds the multiple imaging priced amount for this service. Service provided by Non-Participating Provider. Patient is responsible for charges over the MSP priced amount.
T59	=	Charge exceeds the multiple imaging priced amount for this service. Service provided by Participating/Network Provider. Patient is not responsible for charges over the MSP priced amount.
		<u>The following code is for out of area processing only (BlueCard):</u>
H01*	=	Service provided by a relative of the patient are not covered.
H02*	=	Claim paid in full by other insurance carrier.
H03*	=	This service cannot be processed until charges are filed with other carrier.
H04*	=	Date of service after patient expired date.
H05*	=	Services related to a routine or periodic exam are not covered.
H06*	=	Claim received after time limit for filing claims.
H07*	=	Claim closed until requested information is received.
H08*	=	Payment for this procedure is included in our payment for other services performed on the same day by the same provider.
H09*	=	This provider is not eligible.
H10*	=	Services prior to date of birth.
H11*	=	Handle direct and pay provider directly.
H12*	=	Handle direct and pay subscriber.
H13*	=	Medicare complimentary - handle outside of ITS.
H14*	=	Care was not medically necessary.
H15*	=	Required predetermination has been denied.
H16*	=	Services do not fall within scope of provider license.
H17*	=	Close out claim.
H18*	=	Service lines cannot be split on claims submitted by Host Plan. Host Plan notified to resubmit these services.
H19*	=	Claim submitted by Host Plan cannot be incremented. Host Plan will be notified to re-submit these services.
H20*	=	Misrouted claim - file direct with member's Home Plan.

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H21*	=	Third Party Liability claim - file direct with member's Home Plan.
H22*	=	Subscriber may be balanced billed for provider discount.
H23*	=	Provider contracts with both the Home and Host Plans. Close out claim and instruct provider to bill the Home Plan directly
H24*	=	Close out claim and reprocess it locally under National Account arrangement.
H25*	=	Home Plan requests Host Plan to split claim.
H26*	=	Investigating claim for possible fraud.
H27*	=	Member's Primary Care Physician information is missing or invalid.
H28*	=	Service not covered if provided out of network.
H29*	=	Service is not a benefit under this line of business. Reimbursement to the subscriber will be considered under another line of business.
H30*	=	This product type cannot be processed via the BlueCard delivery program
H31	=	This line of business is processed by a vendor. File directly with the vendor.
H32*	=	This line of business is processed by a vendor. File claim directly with the member's Home Plan.
H33*	=	Subscriber has not responded to request for other coverage information.
H34*	=	Claim denied because the services received for this condition are the responsibility of the no-fault carrier.
H35*	=	Charges are for a verified Medicare Crossover arrangement. Do not resubmit.
H36*	=	The procedure code is inconsistent with the modifier used or a required modifier is missing.
H37*	=	The diagnosis is inconsistent with the patient's age.
H38*	=	The diagnosis is inconsistent with the patient's gender.
H39*	=	Charges for outpatient services with this proximity to inpatient services are not covered.
H40*	=	Not covered unless the provider accepts assignment.
H41*	=	Payment denied because service/procedure was provided outside the United States or as a result of War.
H42*	=	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
H43*	=	Claim adjusted. Plan procedures of a prior payer were not followed.
H44*	=	Claim/service denied. Appeal procedures not followed or time limits not met.
H45*	=	Contracted funding agreement - subscriber is employed by the provider of services.
H46*	=	Prior hospitalization or 30 day transfer requirement not met.
H47*	=	Claim/Service not covered because alternative services were available, and should have been utilized.
H48*	=	Services not covered because the patient is enrolled in a Hospice.
H49*	=	Services not documented in patient's medical records.
H50*	=	Payment adjusted because 'new patient' qualifications were not met.
H52*	=	Benefits reduced because a National Specialty Center provider was not utilized for the procedure performed.
H53*	=	Benefits not available because a National Security Center provider was not utilized for the procedure performed.
H54*	=	Emergency services records needed to complete claim process.
H56*	=	Completed subrogation/workers compensation questionnaire to complete claim process.
H57*	=	Discharge summary needed to complete claim process.
H58*	=	Medicare payment information needed to complete claim process.
H59*	=	Laboratory report needed to complete claim process.
H60*	=	Operative/surgical report needed to complete claim process.
H61*	=	Pathology report needed to complete claim process.

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Ineligible Reason Codes

H62*	= Claim cannot be processed because required pre-authorization is not on file.
H63*	= Radiology report needed to complete claim process.
H64*	= Treatment plan needed to complete claim process.
H65*	= 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.
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.
H67*	= These charges are not covered. Treatment, services or supplies that do not meet our guidelines are not covered under the member's plan.
H68*	= Your dental contract does not cover charges for treatment, services or supplies that do not meet our criteria for medical necessity or are not normally provided for the treatment of this condition.
H69*	= Incidental appendectomies performed without evidence of related illness or injury are not covered.
H70*	= These charges are not covered. As a result of arbitration, these services are the responsibility of the member's automobile insurance carrier.
H71*	= The coordination of benefits information received is incomplete. Other carrier payment information is needed before claim be can processed.
H72*	= Our records indicate this patient has no other health coverage, however this claim was received with another carrier's payment information. These charges will be processed when the other carrier information is verified by the member.
H73*	= Based upon the indication that these services are work related, this claim has been denied.
H74*	= These charges are not covered because the patient has exceeded the number of visits authorized.
H75*	= These maternity charges may not be payable as the member's maximum benefit has been reached.
H76*	= These charges are not eligible because they exceed the maximum number of units authorized.
H77*	= These charges are not covered. The services exceed the maximum number of visits allowed per the member's benefit plan or policy.
H78*	= This service has been paid as an exception to this patient's contract. This exception applies to this claim only.
H79*	= These charges cannot be processed because a detailed description of the service is missing or invalid. This information is needed to determine benefits per the member's benefit plan or policy. These charges will be considered when the requested information is received.
H80*	= These charges cannot be processed until we receive the hospital charges that relate to the professional fee submitted, per the member's benefit plan or policy. These charges will be considered when the requested information is received.
H81*	= Final benefit determination cannot be made until we receive health history information.
H82*	= These charges cannot be processed until we receive medical history information requested from another provider. 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.
H83*	= These charges cannot be processed until we receive additional information requested from you. Your patient has not signed the authorization you require to release the information. These charges will be considered when the completed form and necessary medical records are received.
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.
H85*	= The maximum benefit for services relating to a preexisting condition has been met.
H86*	= These charges for maternity care are not payable because the patient was not continuously covered by the contract from the date of conception through the completion of pregnancy.
H87*	= These charges are not covered. Based upon the information submitted this service is cosmetic.

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Ineligible Reason Codes

H88*	=	These charges are not covered. A surgical room is not covered for this type of surgery performed.
H89*	=	These charges are not covered. Custodial care is excluded under the patient's benefit plan or policy.
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.
H91*	=	These charges are not covered. The patient's primary physician has not approved this out-of-area care.
H92*	=	These charges are not covered because the patient's contract does not allow a second surgical opinion from this type of provider.
H93*	=	The Medicare Part A deductible is not covered under this patient's plan.
H94*	=	The Medicare Part B deductible is not covered under this patient's plan.
H95*	=	These charges are not covered. These services are subject to prior approval under the member's benefit plan or policy.
H96*	=	This payment represents the global rate made to the transplant center as a part of the transplant payment allowance.
H97*	=	This payment represents the global rate for this patient's organ or bone marrow transplant.
H98*	=	Payment for these services has been previously made to the transplant center as part of the transplant payment allowance.
H99*	=	These charges are not covered. Services rendered in connection with dental injury are ineligible under your Plan.
01H*	=	This service could not be covered. The maximum amount allowed for the facility fee for this surgical procedure was paid on a previous claim.
02H*	=	These charges are not covered. Home health services are subject to prior approval under the member's benefit plan or policy.
03H*	=	The bill type submitted on the claim is not compatible with the patient billed status.
04H*	=	No benefits are payable for this service. The primary carrier has paid more than or up to 100% of the allowance.
05H*	=	A description of the services rendered or an itemized listing of charges is needed before the claim can be considered.
06H*	=	The charges shown on the claim do not match those on the EOMB. Please resubmit the claim with the corrected charges or return a Claims Information.
07H*	=	This charge is not covered. Services related to experimental procedures are excluded under the patient's benefit plan or policy.
08H*	=	Counseling services are excluded under the patient's benefit plan or policy.
09H*	=	Custodial care is excluded under the patient's benefit plan or policy.
10H*	=	Routine vision is not covered under this contract. These charges are the member's responsibility.
11H*	=	The line level date of service is invalid for the HCPS/revenue code combination.
12H*	=	Any outlier days and associated ancillaries should be billed on one claim and approved days and approved ancillaries should be billed on another claim per the member's benefit plan or policy.
13H*	=	The services submitted exceed the number of visits previously approved.
14H*	=	Well-baby care is excluded under the patient's benefit plan or policy.
15H*	=	This charge could not be covered, routine physicals are excluded under the patient's benefit plan or policy.
16H*	=	This charge could not be covered, routine physicals are excluded under the patient's benefit plan or policy.
17H*	=	Electroshock therapy services are not covered under the benefit plan or policy.
18H*	=	Convenience items are excluded under the patient's benefit plan or policy.
19H*	=	This type of dental service is excluded under the patient's benefit plan or policy.

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Updated: 10/12/2011

Ineligible Reason Codes

20H*	=	Fluoride treatment is not covered under the patient's benefit plan or policy.
21H*	=	Home health care services are excluded under the patient's benefit plan.
22H*	=	Charges submitted during a leave of absence from the hospital are not covered.
23H*	=	Hearing examinations, tests, hearing aids, and related supplies are excluded under your benefit plan or policy.
24H*	=	This charge could not be covered, since routine immunizations are excluded under your benefit plan or policy.
25H*	=	Non-covered orthopedic supplies, shoes or routine foot care under base and major medical.
27H*	=	Acupuncture services are excluded under the patient's benefit plan or policy.
28H*	=	Biofeedback is excluded under the benefit plan or policy.
29H*	=	The procedure code submitted on this claim is no longer valid.
30H*	=	We have received an EOMB from Medicare. However, we also require an EOB from the patient's other insurance carrier.
31H*	=	A copy of the ambulance report is needed before the claim can be considered.
32H*	=	A copy of the Anesthesia report is needed before the claim can be considered.
33H*	=	We need the physician's office records, the patient's history and physician and/or plan of treatment.
34H*	=	A copy of the current blood gases report is needed before the claim can be considered.
35H*	=	Information about the ordering or referring physician (name/address) is needed before the claim can be considered.
36H*	=	A copy of the psychiatric evaluation, along with the length of session, is needed before claim can be considered.
37H*	=	The name, dosage, quantity and related NDC number of this drug are needed before this claim can be considered.
38H*	=	Height, weight, and frame of the patient are needed before the claim can be considered.
39H*	=	We do not have a valid name and date of birth for this newborn.
40H*	=	A copy of the manufacturer's description of this supply/equipment is needed before the claim can be considered.
41H*	=	A copy of the sleep study report is needed before the claim can be considered.
42H*	=	A copy of the vein study report is needed before the claim can be processed.
43H*	=	A copy of the delivery report is needed before the claim can be processed.
44H*	=	A separate charge for venipuncture/arterial puncture is not covered.
45H*	=	Only the professional component qualifies for reimbursement for this procedure.
46H*	=	Coverage of this item is only considered when the item is purchased.
47H*	=	This service is primarily educational and therefore excluded under the patient's benefit plan or policy.
48H*	=	Artificial conception and/or in-vitro fertilization services are excluded under the member's benefit plan or policy.
49H*	=	These charges are not covered. Pre-authorization of hospice care is required per the member's benefit plan or policy.
50H*	=	These charges are not covered. The services exceed the maximum number of visits allowed for home health care per the member's benefit play or policy.
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*	=	Coverage under the patient's benefit plan or policy is limited to one medical visit per day for the same condition.
53H*	=	Psychotherapy on the same day as electroshock therapy is not covered under the patient's benefit plan or policy.

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Updated: 10/12/2011

Ineligible Reason Codes

54H*	= Pharmacologic management is not covered under the patient's benefit plan or policy when a visit or psychiatric examination is billed on the same day.
55H*	= Charges for partial upper or lower dentures are not covered when the same provider has already billed for complete upper or lower dentures.
56H*	= These charges are not covered. The maximum number of lesion surgical procedures in a single surgical session has been exceeded.
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 member's responsibility.
58H*	= Services performed utilizing interactive audio and video telecommunication systems are not covered under the patient's benefit plan or policy.
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.
60H*	= Modifier TF identifies this as an intermediate level of care which is not listed as a covered service.
61H*	= 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.
62H*	= Newborn hearing tests are only covered under the member's benefit plan or policy when services are rendered by the hospital.
63H*	= Speech therapy is covered under this benefit plan or policy for correction of a speech impairment due to disease, surgery, injury, or congenital anatomical anomaly. Based on the information submitted, this service does not meet this criteria, therefore, this charge cannot be covered.
64H*	= This service is denied because the waiting period for transplant services has not been fulfilled.
65H*	= We need the first consultation date about this condition.
66H*	= Maternity benefits not available for dependent.
67H*	= Home health care services are excluded under your benefit plan or policy when the services are received from a non-contracting home health care agency.
68H*	= Services received in a non-contracting skilled nursing facility are not covered under the patient's benefit plan or policy.
69H*	= This service could not be covered because it is related to a maternity or pregnancy condition. Your benefit plan or policy excludes coverage for maternity or pregnancy related conditions.
70H*	= Routine well baby care not covered on an inpatient basis.
71H*	= This service could not be covered. The patient is not within the age limit for well child benefits under your benefit plan or policy. Routine well baby care not covered on an inpatient basis.
72H*	= Private duty nursing services are not covered for this place of treatment.
73H*	= Claim was automatically crossed over to the member's Personal Savings Account. The provider may be receiving payment for the claim from a 3rd party. These charges are the member's responsibility.
74H*	= The claim has been paid using a price negotiated directly with the Blue Distinction Centers for Transplants (BDCT).
75H*	= Diagnosis or surgical procedure code is not in effect or is incomplete for the Date of Service. Please resubmit with a valid HIPAA Compliant Code for the Date of Service.
76H*	= Per group benefits, as secondary insurer, our liability under this contract is zero.
77H*	= Per member's benefit plan or policy, services were denied because an authorization was approved for an observation stay only.
78H*	= These charges are not covered. The services exceed the maximum number of units allowed per the member's benefit plan or policy.
79H*	= These charges are not eligible because they exceed the maximum number of days authorized.

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Ineligible Reason Codes

80H*	= We are the member's tertiary insurance carrier. Please submit claim to member's primary and secondary coverage carriers. Once claims processed by other carriers please submit claim with both primary and secondary EOB's to your Local Plan.
83H*	= Home Plan pricing used.
84H*	= Member held harmless for the amounts above the provider's maximum DME allowance.
85H*	= Coverage for this item is only considered when the DME item is purchased.
86H*	= Coverage for this item is only considered when the DME item is rented.
91H*	= Final benefit determination cannot be made until we receive medical records that were previously requested on a related claim. No additional information is needed from you at this time.
92H*	= Final benefit determination cannot be made until we receive a tooth number.
93H*	= Maximum visits for physical 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.
94H*	= 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.
95H*	= Final benefit determination cannot be made until we receive x-rays/photos.
96H*	= Final benefit determination cannot be made until we receive the entire psychiatric record with the exception of psychotherapy notes.
97H*	= Final benefit determination cannot be made until we receive the psychiatric assessment/evaluation.
98H*	= Final benefit determination cannot be made until we receive the results of the psychiatric testing.
99H*	= Final benefit determination cannot be made until we receive the psychiatric progress notes or psychiatric team conference notes.
01D*	= Final benefit determination cannot be made until we receive the substance abuse record with the exception of substance abuse therapy notes.
02D*	= Final benefit determination cannot be made until we receive specific requested medical information.
03D*	= This claim is a duplicate to a Medicare Crossover Claim.
04D*	= This claim is rejected due to an invalid diagnosis code.
05D*	= This claim reviewed at the request of the Host Plan.
06D*	= Procedure/treatment has not been deemed proven to be effective.
07D*	= Processed based on multiple or concurrent procedure rules.
08D*	= The related claim/service was not identified on this claim.
09D*	= Rent/purchase guidelines were not met.
10D*	= The information submitted does not support this length of service.
11D*	= The referring provider is not eligible to refer the service billed.
12D*	= The prescribing/ordering provider is not eligible to prescribe/order the service billed.
13D*	= Exceeds the contracted maximum number of hours/days/units by this provider for this period.
14D*	= This provider was not certified/eligible to be paid for this procedure/service on this date of service.
15D*	= This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.
16D*	= Penalty for failure to obtain second surgical opinion.

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