

Remittance Advice Explanation Codes

001	Postpone payment of claim > 2 weeks	045	Auto Action eligibility other
002	Increased allowable	046	Auto Action ineligibility other
003	Reduced allowable	047	Earliest Agreement Override
004	Reduced copayment	048	ASC Multiple Procedures Reductions Taken
005	Increased copayment	049	ASC Default Category Reductions Taken
006	Reduced deductible	050	Provider Payment Adjustment
007	Increased deductible	051	Provider Surcharge Amount
008	Approved by Utilization Mgmt	052	AE Criteria Override
009	Approved by Customer Service	053	Extra Contractual Override
010	Reduced coinsurance	054	Services Denied.Contact Delegated Entity
011	Increased coinsurance	055	Eligibility Verified
012	Override prompt pay discount	056	Multiple Surgery disallowed
013	Using TOS for Durable Med Equipment	057	FSA Paid Amount Override
014	Using TOS based on Place of Service	058	Bypass FSA Processing Override
015	Increased allowable amount per unit	059	Bypass HRA Processing
016	Reduced allowable amount per unit	060	Not a covered FSA service
017	Increased allowable units	061	HRA Paid Amount override
018	Reduced allowable units	062	FSA dollars exhausted
019	Disallowed amount	063	Bypass FSA Runout Period Override
020	Pay not a duplicate service	064	Bypass Duplicate Edit
021	Pay different provider of service	065	Non covered HRA service
022	Pay terminated member's claim	066	HRA Only service
023	Dates of service span member's plans	067	Patient Liability Disallow Override
024	Reprocessed claim-suppress EOB	068	No Pledge Amount on file
025	Dates of service matched	069	No Pledge Amount on file
026	Dates of service overlap	070	Dependent claim line partially paid
027	Provider of service matched	071	Funds exhausted
028	Premium pd. thru date overridden	072	Additional NetworX Data
029	Pay not cosmetic	073	Deny All Claim Lines
030	Patient Transfer to Acute Care Facility	074	Alternate Room Type
031	Statistical Claim Adjustment	075	Automated HRA Payment Bypassed
032	Bypass Automatic Overpayment Recovery	097	HRA Deductible Override
033	Subscriber Payment Override	098	Duplicate Claim Level Override
034	Claim Preauth Requirement bypassed	100	Claim Adjustment Reason
035	Claim Referral Requirement bypassed	101	Miscellaneous Data
036	Line Level Preauth Requirement bypassed	102	NetworX Service Rule override applied
037	Line Level Referral Requirement bypassed	103	NDC code priced
038	Externally Created Payment	104	Claim level disallow
039	EOB Statement Explanation	105	COB Disallow
040	Referral/Pre-auth Violation	106	Dental Consultant Review
041	Line Level Service Rule Override	107	Service was not identified on the claim
042	Claim Level Interest Clean Date Override	108	Payment adjusted rent/purchase policy.
043	UM Pre-auth Denial/MD Review	112	Pmt adjusted as not furnished to patient
044	UM Referral Denial/MD Review	114	Procedure/product not approved by FDA

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BMC HealthNet Plan – Remittance Advice Explanation Codes

115	Payment adjusted procedure postponed	331	Secondary Payor Pricing Qualifier
119	Benefit maximum for this time period.	332	ITS SF Adjustment Pend
125	Payment adjusted due to billing error(s)	333	ITS OPL Calculation Method
128	Newborn's services are covered under Mom	334	ITS Plan Payer Code
130	FSA Prior Year Paid	335	ITS Classification of Provider
131	Claim specific negotiated discount.	336	ITS Referral status override
133	The disposition of claim pending review	337	ITS PCP Referral override
134	Technical fees removed from charges.	338	ITS Review Determination Code override
138	Appeal process not followed	339	ITS Performing Provider POS override
141	Adj. -Claim spans elig/inelig coverage	34	Denied coverage for newborns.
15	Payment adjusted auth mismatch	340	ITS Pre-authorization status override
19	Claim denied work-related injury/illness	341	Wrong Provider Paid
20	Claim denied covered liability carrier.	342	Wrong Subscriber Paid
200	Audit in Progress	343	Wrong Payee
201	Interest is being recouped.	344	Retroactive Cancellation
202	Original Line	345	Benefits
203	Variable Component Tier Override	346	Duplicate
204	Automatic Payment Level Override	347	Lost/Damaged Check
21	Claim denied liability no-fault carrier.	348	Worker's Comp
22	Payment adjusted covered another payer	349	Medicare
23	Payment adjusted paid by another payer	35	Lifetime benefit has been reached.
250	Capitated HRA Service	350	Subrogation
300	ITS Pricing Method Override	351	COB
301	ITS Primary Pricing Rule Override	352	Incorrect Subscriber ID
302	ITS Secondary Pricing Rule Override	353	Patient Change
303	ITS Processing Bypassed	354	Incorrect Reject
304	ITS SF Claim Level Message Code	355	Late Managed Care Data Sent by Par Plan
305	ITS SF Line Level Message Code	356	Incorrect Provider/PCP Data
306	ITS Adjustment Not Approved	357	ITS Alpha Prefix Actual
307	ITS User Explanation Code	358	ITS Line of Business
308	ITS Savings	359	ITS Primacy Indicator
309	ITS Prior Status Code	360	ITS MPPQ Assigned
312	ITS Special Pricing Condition Code	361	ITS MPPQ Unassigned
313	ITS Payment Reduction Reason Code	362	ITS ECR Indicator
314	ITS DF Claim Level Message Code	363	ITS Surcharge Amount
315	ITS DF Line Level Message Code	364	ITS Total Patient Liability
318	Claim sent to Home Plan	365	ITS HVA Incorrect Reject
319	ITS DF Value Override	366	ITS HVA Benefit Change
320	ITS Host Amount Exceeded Maximum	367	ITS HVA Pricing Change
321	ITS Admin Fees Applied	368	ITS HVA Wrong Classification of Provider
322	ITS Access Fees Applied	369	ITS HVA Medicare
323	ITS Line Item Discount	370	ITS Other HVA Home
324	ITS COB Savings Override	371	ITS Other HVA Host
325	ITS LIL Revert to Charges	372	ITS ASO Indicator Override
326	ITS Bypass Line Item Link	373	ITS Private Room Differential Override
327	ITS LIL Bypass Message Codes	374	ITS Bypass Host/ECRP Check
328	ITS One Time Business Decision	375	ITS Supplemental Amount
329	ITS CFA Disposition Date	376	ITS Private Room Not Covered
330	ITS SF Adjustment Pend	377	ITS OPL Prov. Arrangement Code Override

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378	Home Control - One Time Exception	AH6	Value code is invalid
379	No Fault	AT1	Diag
38	Services not provided or authorized.	AT2	Procedure & Revenue Codes are invalid
380	Medicare Audit	AT3	Diagnosis & Revenue Codes are invalid
381	Awaiting Primary Payment	AT4	Diagnosis & Procedure codes are invalid
382	Medicare Paid Primary In Error	AT5	Revenue code invalid
383	Provider Appeal	AT6	Procedure code and/or modifier invalid
384	Host/Par - One Time Exception	AT7	Diagnosis code invalid
385	Provider Billing Error	AU1	Diag
386	ITS Original From Date Override	AU2	Procedure & Revenue Codes are invalid
387	ITS Original To Date Override	AU3	Diagnosis & Revenue Codes are invalid
39	Services not authorized.	AU4	Diagnosis & Procedure codes are invalid
4	Inconsistent procedure/modifier	AU5	Revenue code invalid
40	Charges do not meet ER/UC qualifications	AU6	Procedure code invalid
42	Charges exceed our allowable amt	AU7	Diagnosis code invalid
45	Charges exceed your contracted amt.	AUD	Audit Completed
49	These are non-covered services.	B12	Services not documented in pts' records
50	Not deemed a medical necessity by payer	B13	Previously paid.
54	Multiple assistants are not covered.	B14	Payment denied. Only one visit per day
55	Denied. Experimental/investigational	B15	Pmt adj service is not paid separately
58	Payment adjusted. Inappropriate pos	B16	Adj -New Pt qualifications not met
59	Adjusted charges multiple surgeries.	B18	Pmt denied inv proc/mod combination
65	Procedure code was incorrect.	B1A	DATA:Incorrect Provider Keyed
69	Day outlier amount.	B1B	DATA:Units/Days Entered Incorrectly
70	Cost outlier	B1C	DATA:Modifier Entered Incorrectly
701	Investigative Procedure Disallow	B1D	DATA:Proc/Rev Code Entered Incorrectly
702	Cosmetic Procedure Disallow	B1E	CONTProvider Contract/Fee Schd Incorrect
703	Outdated Procedure Disallow	B1F	MO:Pricing or Contract Load Incorrect
704	Invalid Procedure Disallow	B1G	MO:Config/Rule Bank Issue
705	Related Procedure Disallow	B1H	GENL:Incorrect Benefits Manually Applied
78	Non-Covered days/Room charge adjustment.	B1I	GENL:Clinical Edits Not Followed
88	Adjustment amount prior overpayment.	B1J	GENL:Manual Adjudication Incorrect
89	Professional fees removed from charges.	B1K	GENL:Claim Paid To Incorrect Provider
94	Processed in Excess of charges.	B1L	GENL:CIm Denial Incorrect/Wrng Denial Cd
95	Benefits adjusted. Policy not followed.	B1M	GENL:Duplicate/Overpayment Retraction
96	Non-covered charge(s).	B1N	PDI: Provider Setup
97	Payment included in another procedure.	B1P	PLAN: Clinical Edits Reversed by Plan
A0	Patient refund amount.	B1Q	DATA: Member Entered Incorrectly
A01	Sanction Penalty	B20	Payment adjusted
A2	Contractual adjustment.	B21	Charges were reduced
AAR	Reduced For Automatic Recovery	B27	Multichannel laboratory reimbursement
ADC	Average Daily Charges Stoploss Provision	B5	Adj. guidelines not met/exceed
AF1	AF Contract Period Override	B6	Pmt adj when prfmd by this Fac/Prov/Spec
AGN	Invalid Agreement Relationship	B7	Provider not eligible to be paid for dos
AH1	DRG is invalid	CAP	Capitated Services
AH2	Admission Source code is invalid	CBI	COB Information not received
AH3	Condition code is invalid	CBN	Primary Carrier Information Required.
AH4	Occurrence Span code is invalid	CD0	Default Disallow
AH5	Occurrence code is invalid	CDD	Duplicate Claim

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CG0	Tier not found	IAN	ITS LIL coinsurance amount
CG1	Rule not set	IAT	ITS LIL allowable amount per unit
CG2	Covered Amount > Category Allow Amt	IAU	ITS LIL allowable units
CG3	Cov Amount > Ctgy Allow Amount + Hist	IAX	ITS LIL disallow amount
CG4	Covered Ctr > Category Allow Ctr	IIK	System Gen. ITS LIL Revert to Charges
CG5	Cov Ctr > Ctgy Allow Ctr + Hist	IN	Inlier Pricing
COB	Pd Limit Accum Altered by COB Adjustment	INH	ITS No Hold Harmless Allowable Override
CPD	Possible Claim Duplicate	IPR	ITS Private Room Non-Covered Amount
CRO	Line Level Category Rule Override	ISS	Invalid Sex For Service Rendered
CVX	Coverage Exclusion	LS2	Stoploss Based on Charge
D01	Increased Dental allowable	MLN	Please submit primary dx
D02	Decreased Dental allowable	MSD	Multiple Same Day Surgery Reductions
D03	Increased Dental copayment	MUT	Override Medical Utilization Edits
D04	Decreased Dental copayment	N01	Incidental to or part of primary code
D05	Increased Dental deductible	N02	Redundant Procedure Disallow
D06	Decreased Dental deductible	N03	Secondary Procedure Disallow
D07	Dental Limits bypassed-by Customer Serv	N04	Included in Global Rate
D08	Dental Limits bypassed-by Util Mgmt	N05	Same Day Procedure Disallow
D09	Increased Dental coinsurance	N06	Assistant Surgeon Disallow
D10	Decreased Dental coinsurance	N08	No Criteria found for procedure
D11	Increased Dental allowable amt per unit	N09	Cosmetic Procedure Disallow
D12	Decreased Dental allowable amt per unit	N10	Investigational Procedure Disallow
D13	Increased Dental allowable units	N11	Outdated Procedure Disallow
D14	Decreased Dental allowable units	N12	Procedure has Info
D15	Dental Disallow amount	N13	Invalid Procedure Disallow
D16	Pay	N14	Invalid Gender for Procedure
D17	Pay	N15	Age exceeds normal range for procedure
D18	Pay Dental claim - terminated member	N16	Age exceeds extreme range for procedure
D19	Dental Utilization Edits bypassed	N17	Invalid place of service for procedure
D20	Dental Premium Paid Thru Date override	N19	Invalid Diagnosis for Procedure
D21	Submit Ortho Tx date	N25	Charges were combined into primary proc
D22	Submit x-ray(s) for procedure	N26	Pretreatment Procedure Disallow
DAP	Dental Alternate Procedure Explanation	N27	Invalid Modifier Disallow
DIS	Agreement Discount Off Charges	N29	Clinical Daily Maximum Exceeded
DP0	Member age exceeds procedure norm	N30	Lifetime Maximum Exceeded
DP1	Dental procedure not valid for teeth	N50	Current Procedure Rebundle
DP2	Covered Amount > Procedure Allow Amt	N51	History Procedure Rebundle
DP3	Cov Amt>Proc Allow Amt+Hist or Curr Clm	N52	Duplicate Uni or Bilateral Procedure
DP4	Covered Ctr > Procedure Allow Ctr	N53	Dup History Uni or Bilateral Procedure
DP5	Cov Ctr>Proc Allow Ctr+Hist or Curr Clm	N54	Daily or Lifetime Max Occurrence
DUP	Duplicate Claim Line	N55	History Daily/Lifetime Max Occurrence
EXD	Excess Days	N56	Duplicate Procedure Submitted
EXR	External Referral Received	N57	History Dup Procedure Submitted
GLB	Disallow--global case	N58	History Mutually Exclusive Procedure
GLD	Global Case Rate Override	N59	History Incidental Procedure
HLD	Claims Payment Hold	N60	Assistant Surgeon Sometimes Required
IAA	ITS LIL allowable amount	N61	Age Conflict Replaced Procedure
IAC	ITS LIL co-pay amount	N62	Gender Conflict Replaced Procedure
IAD	ITS LIL deductible	N63	History Procedure Added Line Rebundle

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N64	History PreOp Conflict Within 1 Day	PAR	Exceeds the Per Diem/Per Case Rate
N65	History PostOP Conflict within 90 Days	PBA	Benefits Based on Admission Date
N66	History Medical Visit Conflict	PBB	Admission Date Benefit Calc Bypassed
N67	New Pt Visit Conflict Procedure	PBM	Major Medical Benefits Applied
N68	Intensity of Service Conflict	PCD	Service Pricing Disallow
N69	Duplicate Component Billing Conflict Cur	PCO	PCA Pend Override
N71	Multiple Component Billing Conflict	PCW	Proc. Control Agent Workflow Disallow
N73	Third Party Liability Potential	PDA	Agreement Straight Discount
N74	SmartSuspense edit	PDC	Agreement Discount
N75	History SmartSuspense edit	PDD	Discount Based on Default for Charges
N76	Invalid Procedure Modifier Combination	PDP	Agreement Discount from Charges
N77	Invalid Modifier	PDR	Payment Date Override
N78	Invalid Diagnosis Code	PE0	Exceeds the DRG Outlier
N79	Units Expansion Failed	PEN	Reduction Based On Service Penalty
N80	Facets ClaimCheck N80	PEO	Exceeds the DRG Outlier
N81	Facets ClaimCheck N81	PEX	External Pricing Disallow
N82	Facets ClaimCheck N82	PFC	Paid at Profile Rate
N83	Facets ClaimCheck N83	PFS	Paid at Profile Rate
N84	Facets ClaimCheck N84	PFU	Exceeds Profile Anesthesia Rate
N85	Facets ClaimCheck N85	PFV	Exceeds the Profile RVU x CVF
N86	Facets ClaimCheck N86	PFW	Exceeds the Profile Anesthesia Rate
N87	Facets ClaimCheck N87	PGA	Exceeds DRG Amount
N88	Facets ClaimCheck N88	PGD	Exceeds the DRG Outlier Discount
N89	Facets ClaimCheck N89	PGE	Exceeds DRG Rate
N91	CCI Incidental Procedure	PGO	Exceeds the DRG Outlier Aggregate
N92	History CCI Incidental Procedure	PGP	Exceeds the DRG Outlier Per Diem
N93	CCI Mutually Exclusive Procedure	PGR	Exceeds DRG Rate x WT
N94	History CCI Mutually Exclusive Procedure	PIM	ITS Medicare Pricing Disallow
N95	Assistant at Surgery Procedure	PIX	ITS SF Pricing Disallow
N96	McKesson User Defined Disallow	PL	Payment Level Override
O25	Charges Comb'd due to Dent Clin Edit	PLA	Average Daily Charges Stoploss Met
OAS	Patient Over Allowable Age for Service	PLC	Medicare Limiting Charge Applied
OCA	Override Claim Accept Months	PLE	Encounter Units applied for this service
OOA	Out of Area	PLO	Other Party Liability Disallow Override
OUT	Outlier Pricing	PLP	Percent Threshold Stoploss Met
OV1	Claim adjustment applied	PLT	Stoploss
OV2	Overpayment Recovery	PMI	Procedure Modifier Combination Invalid
OV3	Approved for Payment Upon Appeal	PMM	Minimum Provision
OV4	INC adjustment applied	PMP	Modifier Pricing Applied
OV5	Pay	PMX	Maximum Provision
OV6	Denied-No Preauthorization or Referral	PPC	Exceeds the APC rate
OV7	Denied-No Preauthorization or Referral	PS	Exceeds Service Amount
PAA	Exceeds Per Case Rate	PS0	Not a Covered Service
PAC	Exceeds Per Case Rate	PS1	Exceeds the maximum allowable
PAH	APC Rate	PS2	Exceeds the maximum number of units
PAI	Paid at Per Diem Rate	PS3	History Max Units/Per Month Exceeds
PAK	Exceeds Per Diem Rate	PSB	Exceeds RBRVS Rate
PAL	Exceeds Per Diem/Per Case Rate	PSC	Exceeds the R&C Rate
PAP	Exceeds Per Diem Rate	PSM	Exceeds the MDR Anesthesia Rate

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PSR	Exceeds Rate Entered	Q1N	CONTR:Retro Provider Contract Update
PSS	Paid at Contracted Rate	Q1O	CONTR:Exception Override
PSU	Exceeds the Anesthesia Rate	Q1P	APPEAL:CIm Decision Overturned on Appeal
PSV	Exceeds the RVU x CVF Rate	Q1Q	APPEAL:Claim Denial Upheld on Appeal
PSW	Paid at Anesthesia Rate	Q1R	PROV: Replacement Claim Received
PTR	Procedure Tiers Calculation Applied	Q1S	AUTH: Auth Entered Incorrectly
PX1	Manual pricing applied	Q1T	PLAN: Retroactive Rate Update
PX2	Cost	Q1U	PROV: Claim Submitted for Incorrect Mbr
PX3	Cost + Pct	Q1V	PROV: Clm Den/Retrct due to Clin Ed
PX4	Cost + Pct/No Cost Chg	RTO	Automatic Room Type Override
PX5	Cost + Pct w/ Threshold	RWD	Risk Withhold Disallow
PX6	Cost + Pct w/ Threshold or No Cost Chg	S10	Date req. after Subgroup Termination
PX7	Cost/No Cost Chg	S11	Date Req. Prior to Group Effective Date
PX8	Cost w/ Threshold	S12	DOS prior to Subscriber Orig Eff Dt
PX9	Disc Excess Days	S13	Member not enrolled on DOS
PXA	Disc + Per Diem	S14	Date requested prior to plan-entry date
PXB	ASC Grouper	S15	More than one class/plan entry found.
PXC	ASC Grouper	S16	No plan selection event found
PXD	ASC Grouper	S17	Ineligibility due to unpaid premium
PXE	ASC Grouper	S1A	No eligibility found
PXF	ASC Grouper	S1B	Plan not found
PXG	ASC Grouper	S1C	Plan not effective on date requested
PXH	ASC Grouper	S1D	PDBC row not effective on date requested
PXI	ASC Grouper	S1E	No AIAI row with the PDBC prefix.
PXJ	Anesthesia Schedule	S1F	No GPAI row in effect
PXK	Anes Sched	S1G	Bill not on file
PXL	APC w/ Base Rate	S2	Date requested < Subscriber's Birth Date
PXM	ASC Except Amt & Pct w/ Proc Max	S20	Date req. prior to Member Orig. Eff Date
PXN	NetworX Std Fee Sched	S21	Date req. prior to Group Effective Date
PXO	Service + Cost Less Pct	S22	Date req. prior to subgroup orig eff dt.
PXP	Service + Cost Plus Pct	S23	DOS prior to Subscriber Eff Dt
PXQ	Cost Plus Charges	S24	Part A or B not active for member
PXR	Border Baby Days	S25	Enrollment on hold status
PXS	Mileage	S3	Date requested < Member's Birth Date
PXT	Combined Mom/Baby Charges	S4	Eligibility spans multiple plans
PXV	Dental Fee Sched	S5	Member not eligible for product category
Q1A	PROV:Corrected Claim Received	S6	Member is over dependent age limit
Q1B	PROV:Itemized Bill Received	S7	Subscriber is over subscriber age limit
Q1C	PROV:EOB Received From Primary Carrier	S8	Spouse is over the spouse age limit
Q1D	PROV:Received Requested Info	S9	Date requested after Group term date
Q1E	PROV:Provider Billing Error	S?	Ineligibility not caused by an event.
Q1F	PROV:Timely Filing Proof Received	SB	Subscriber & Spouse only enrolled.
Q1G	PROV:Late Billing Received	SC	Subscriber Only enrolled.
Q1H	PROV:Invoice Received	SD	Subscriber & Dependent Child(ren) enroll
Q1I	PROV:Auth Added/Updated Retroactively	SE	Spouse and dependents only
Q1J	ENRO:Retro Term of Member Contract	SF	Spouse only coverage
Q1K	ENRO:Member PCP Retroactively Updated	SG	Dependents only enrolled
Q1L	ENRO:Retro Activation of Member Contract	SL	Retired - No benefits
Q1M	CONTR:Timely Filing Requirements Waived	SM	Deceased Member

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SN	Non-eligible member	X1D	Claim orig. denied - readjusted for COB
SO	Termination - ineligible	X1E	Payment reduced for COB
SP	Termination - Non payment of premium	X1F	Payment reduced after primary plan paid
SPD	Supplemental Discount	X1G	Denied: Worker's compensation is primary
SQ	Termination - Divorce	X1H	Retraction: Bill WC for payment
SS	Separation - Member	X1I	Denied: PIP benefits avail. up to \$8000
ST	Termination-Member Ineligible	X1J	Retracted: Auto insurance is primary
SW	Termination - COBRA	X1K	Clm. orig. denied but readjusted for TPL
TBD	ITS Private Room Non-Covered Amount	X1L	Payment reduced after liability ins. pd.
TF0	Submitted after plan filing limit	X1M	Refund check received - Pharmacy
TF1	Submitted After Provider's Filing Limit	X1N	Prov. requested retraction - credit bal.
TR0	Service not covered	X1O	Prov. requested adjustment - credit bal.
TR1	Rule not set	X1P	Retraction - prim. pharmacy coverage eff
TR2	Covered Amount > Service Allow Amt	X1Q	Denied - prim. pharmacy coverage eff.
TR3	Covered Amount > Srv allow + rel hist am	X1R	OPL savings processed outside OPL module
TR4	Covered Ctr > Service Allow Ctr	X1S	Payment for Coordination of Benefits
TR5	Covered Counter > Srv Allow Ctr+rel hist	X1T	CB/COB RETRACTION
TR6	COB Subtraction Method Disallow	X1U	CB/COB 2NDARY BAL
UAS	Patient Under Age For Service Rendered	X1V	CB/TPL RETRACTION
UD	Utilization Management Disallow	X1W	CDR/COB RETRACTION
UED	Utilization Edit Denial	X1X	CDR/COB 2NDARY BAL
UM0	Services Disallowed by Plan	X1Y	CDR/TPL RETRACTION
UM1	Units exceed UM authorization	X1Z	EXT/COB RETRACTION
UM2	Units reduced by UM authorization	X20	Invalid Bill Type/ Billing/Claim Form
UM3	Pended Status	X21	Invalid admit source
UM4	Calendar year warning applied	X22	Resubmit with Purchase Invoice
UTM	Medical Utilization Edits Applied.	X23	Provider terminated at time of service
X01	Overpayment Recovery Applied	X24	Resubmit with itemized bill
X02	Resubmit with valid tax ID number	X25	Resubmit with units
X03	Paid by other Insurance	X26	Exceeds 100 days submit to Mass Health
X04	Denied by Medical Review	X27	Not a Plan Benefit submit to Mass Health
X05	Denied by Behavioral Health Review	X28	Auth required > 24 visits
X06	Resubmit with OP notes or reporting	X29	Auth required > 12 visits
X07	Referral not valid for DOS	X2A	EXT/COB 2NDARY BAL
X08	Provider not authorized to perform serv	X2B	EXT/TPL RETRACTION
X09	Resubmit to primary Insurance	X2C	CDR Retraction
X10	Patient length of stay exceeded pre-auth	X2D	Ext Retraction
X11	Resubmit with DRG number	X30	Denied - DMA State Codes Missing
X12	Accident 3rd party liability	X31	Percent of Charge Pricing
X13	Included in Global Rate	X32	Denied-No Preauthorization or Referral
X14	Resubmit with valid ASA code	X33	Provider not contracted to render serv
X15	Resubmit with valid DME modifier	X34	Resubmit with Purchase Invoice
X16	Claim paid by primary health insurance	X35	Resubmit with Operative Report
X17	Resubmit with actual minutes	X36	Invalid Procedure/Rev Code/Dx
X18	Invalid Patient Status	X37	Claim Adjustment Applied
X19	Invalid Admit date	X38	Overpayment Recovery
X1A	Submit to primary ins. & resubmit w/ EOB	X39	Pay
X1B	Retraction: Other insurance is primary	X40	Invalid procedure/modifier combination
X1C	Denied: Submit primary ins. information	X41	Duplicate Claim

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X42	Duplicate Claim	X91	Multiple Same Day Surgery Reductions
X43	Denied - Non-Covered Plan Benefit	X92	Multiple Same Day Surgery Reductions
X44	Invalid Place of Service	X93	Resubmit with Rental Invoice
X45	Adjusted Previously Paid	X94	Resubmit with Rental Invoice
X46	BH TOS Adjustment Applied	X95	Denied-mbr not assigned to coverage grp
X47	Claim submitted for Incorrect Member	X96	Resubmit with valid BH modifier
X48	Non-covered service	X97	Per Unit / Fee Schedule Rate Applied
X49	Claim submitted for Incorrect Member	X98	Med Svcs Not Paid Under BH Provider
X50	Non-covered service	X99	Pended For Per/Hour Pricing Adjustment
X51	Pay	XIT	Denied :PIP benefits avail. up to \$2000
X52	Denied - Submit to MVA carrier	XU1	UM Unlimited Units
X53	Denied - Submit to WC carrier	XZ0	Override Request - Approved
X54	Denied - Submit to MVA carrier	XZ1	CRU Adjustment
X55	Denied - submit to WC carrier	XZ2	Appeal - Clinical Edit - Approved
X56	Claim adjustment MVA/WC paid for DOS	XZ3	Appeal - Timely Filing - Approved
X57	Claim incorrectly paid to provider	XZ4	Appeal - Medical necessity
X58	Incorrect Billing	XZ5	Appeal - Authorization - Approved
X59	Included in Per Diem/Global payment	XZ6	Appeal - Second Level - Approved
X60	Incorrect Billing	XZ7	Appeal - Second Level - Approved
X61	Included in Per Diem/Global Payment	XZ8	Appeal - Second Level - Approved
X62	Retraction - line deleted from claim	XZ9	Override Request - Approved
X63	Paid at UM/Negotiated Rate	XZA	Override Request - Approved
X64	Procedure Code Required	Y01	Svcs billed is not a BMCHP cov benefit
X65	Paid at Negotiated Fee	Y02	Retro disenrollment - payment retracted
X66	Claims processed for incorrect member	Y03	Clm reprocessed due to retro contract
X67	Claims processed for incorrect member	Y04	Non-con DMA rate alwd for non-con prov
X68	Auth Not Obtained-Potentially Cosmetic	Y05	Contracted rate allowed Reimbursement change per DMA rate change
X69	Benefit limited to member under 21	Y06	Fee schd incorrectly driving clm pymt
X70	COB Adjustment	Y07	Fee schd incorrectly driving clm pymt
X71	Contractual Adjustment	Y08	Capitated Svcs
X72	Adjustment to units paid	Y09	Fee For Service rate applied
X73	Overpayment Recovery	Y10	Clm reprocess after int sentinel review
X74	Claim incorrectly paid to provider	Y11	manual adj correct systematc auto error
X75	Duplicate Payment	Y12	Duplicate pymt due to splitting of claim
X76	Claim paid for incorrect member	Y13	Dup/incr pymt result from clm override Dup SPADs pd for newbn using mom/baby ID
X77	Resubmit with Purchase Invoice	Y14	Dup/incr pymt due to multi prov# in sys
X78	Refund check received-External Audit	Y15	Dup/incr pymt due to data entry error
X79	Refund check received-Credit balance	Y16	Dup/incr pymt due to data entry error
X80	Refund Check Recd - Duplicate Claim	Y17	Multi mod resulted in incr man pricing
X81	Refund Check Recd - Wrong Provider	Y18	Clm Edit/adj error by reviewer
X82	Refund Check Recd - Void BMCHP Check	Y19	Lt chrgs incld in SPAD pymt Case/Diem
X83	Refund Check Recd - Multiple Issues	Y20	Unbilled chrg acpt during onsite med rev
X84	Refund Check Recd - Charges Removed	Y21	Interim bill resulted in overpayments
X85	Refund Check Recd - Wrong Member	Y22	SPAD pd rather than correct Tran perdiem
X86	Refund Check Recd - Misc. See Notes	Y23	Billing error reslt in SPAD pymt BH svc
X87	Refund Check received - TPL	Y24	BH rates allowed per Auth CPT/HCPCS code unbundled per CCI and CPT
X88	Refund Check received - COB	Y25	Mod not applied per CPT code guideline
X89	Invalid Rev/Procedure Code combination	Y26	Incorrect modifier applied
X90	Multiple Same Day Surgery Reductions	Y27	

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BMC HealthNet Plan – Remittance Advice Explanation Codes

Y28	Recorded per documentation in med record	Z17	TB bypass auth requirements
Y29	Recorded per CPT/HCPCS coding guidelines	Z18	Not eligible for Purchase
Y2A	Retro term	Z19	Not eligible for Rental
Y2B	Retro term	Z20	Resubmit w/Anesth (ASA) Crosswalk Codes
Y30	Prov billed using incorrect svcs vend#	Z21	Incorrect Units billed
Y31	Provider billed using incorrect mem ID	Z22	Resubmit Late Charge w/complete bill
Y32	Svcs billed not documented in med record	Z23	Svcs/Supply cannot be billed in advance
Y33	Clm process incrtly/ how auth was issue	Z24	Procedure code billable only once p/day
Y34	Auth match logic selected incorrect Auth	Z25	Rebill w/more specific code/description
Y35	Auth required for services	Z26	Resubmit with Masshealth EOB
Y36	Auth for svsc denied/disallowed	Z27	Resubmit itemized bill for Elig/cov days
Y37	Auth days/visits differ from svcs on clm	Z28	Resubmit with NDC#
Y38	Appropriate auth on file for svcs billed	Z29	Resubmit w/modifiers in correct
Y39	Not Currently being used	Z30	Resubmit with correct modifier(s)
Y40	Miscellaneous Provider issue	Z31	Denied - Non-Covered Service - WRAP Bnft
Y41	Miscellaneous Claims processing issue	Z32	Denied - Non-Reimbursable Code - Billing
Y42	Miscellaneous Dup claims payment issue	Z33	Denied - Non-Covered Benefit
Y43	Miscellaneous Authorizations issue	Z34	Denied - Non-Covered Investigationl Srvc
Y44	Not Currently used	Z35	AuthNot Obtained-Potential Investigative
Y45	Overcharges identified onsite hosp audit	Z36	Resubmit with correct modifier(s)
Y46	Case Rate override to allow % of chrg	Z37	Denied - Avail. through spec. pharmacy
Y47	Bilateral audit adjustment	Z38	Denied per Medical Director Review
Y48	CCI audit adjustment	Z39	Illegible/Invalid Date of Service
Y49	Global audit adjustment	Z40	Included in Per Diem/Global payment
Y50	Infertility not a covered service	Z41	Disallow - Submit Claim to VSP
Y51	IV Therapy reimbursed OP only	Z42	Disallow-Chiro Service not covered
Y52	Mod Sed not a covered service	Z43	Disallow-Infertility Service not covered
Y53	MRI Audit adjustment	Z44	Disallow - Orthotic Service not covered
Y54	Prev Care CPT audit adjustment	Z45	Disallow - Disposable supply not covered
Y55	PulseOx covered only with approved diag	Z46	Disallow - Podiatry Service not covered Copay Out of Pocket Maximum has been met
Y56	Spec Coll not a covered service	Z47	
Y57	Unlisted audit adj-sub record for appeal	Z48	Coins Out of Pocket Max has been met
Y58	Venipuncture not covered w/office visit	Z49	Member Co-payment waived
Z01	Invalid Procedure Code	Z50	Co-payment adjustment
Z02	Invalid Revenue Code	Z51	Out of Pocket Adjustment
Z03	Invalid Diagnosis Code	Z52	Coinsurance Adjustment
Z04	Incorrect revenue code for service	Z53	Physicals for School/ Admin Not Covered
Z05	Procedure code required	Z54	Disallow-Incidental Service not covered
Z06	Rebill with correct procedure/HCPCS code	Z55	Pharmacy denial MD reviewed
Z07	Invalid POS for procedure	Z56	Product Split
Z08	Rebill with correct procedure code	Z57	Coinsurance Waived
Z09	Included in PAPE rate	Z58	Coinsurance taken on previous claim
Z10	Externally Created Payment	Z59	Manual coinsurance adjustment
Z11	Pay	Z60	Co-payment waived
Z12	Benefit limited to member under 3	Z61	Co-payment taken on previous claim
Z13	Limited benefit - based on diagnosis	Z62	Manual co-payment adjustment
Z14	Not a valid provider of service.	Z63	Claim spans agreement dates
Z15	Services denied due to other funding.	Z64	Member changed products
Z16	Incorrect claim form for this service	Z65	Daily Unit Max is reached

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BMC HealthNet Plan – Remittance Advice Explanation Codes

Z66	Not covered for diagnosis code billed	x17	Unbundled Lab Service
Z67	Exceeds the maximum number of units	x18	Unbundled Lab Service
Z68	Included in PAPE Primary Payment	x19	Unbundled Service
Z69	Disallow - Rebill to Dental Carrier	x20	Unbundled Service
Z70	New Procedure Code Under Review	x21	Unbundled Service
Z71	Outlier Threshold Met	x22	Unbundled Service
Z72	Procedure code billed is not correct/val	x23	Unbundled Service
Z73	Denied - Non-Covered Plan Benefit	x24	Unbundled Service
Z74	Denied-No Preauthorization or Referral	x25	Unbundled Service
Z75	Per Nurse review claim denial upheld	x26	Unbundled Service
Z76	Per Nurse review claim denial overturned	x27	Svcs not typically performed together
Z77	Disallow - Non reimbursable service	x28	Svcs not typically performed together
Z78	Deny Invalid CPT/ HCPCS to Rev Code	x29	Mutually Exclusive Services
Z79	Included in Room and Board	x30	Mutually Exclusive Services
Z80	MedSolution administrative denial	x31	Codes indicate sex conflict
Z81	Out of Pocket Expense has been met	x32	Codes indicate sex conflict
Z82	Specialty/Reg Formula Not Med Necessary	x33	Mutually Exclusive Services
Z83	Svc cov'd under other municipal program	x34	Unbundled Service
Z84	resubmit with appropriate NPI	x35	Modifier on code 1 or code 2
t01	Modifier required at this POS	x36	Diagnosis denied by statute
u01	Anestheisa Limit Exceeded	x37	Code is not currently valid
u50	Bilateral Unbundling	x38	Code not valid for svc date
u51	Bilateral Unbundling-History	x39	Code not covered by Medicare
u52	Bilateral Unbundling	x40	Code not covered by Medicare
u53	Bilateral Unbundling-History	x41	Code does not have support dx
w01	Digits 4	x42	Code violates age constraints
w02	Invalid patient admission date	x43	Age reqs for code but no age
w03	Not found in valid code table	x44	Code violates sex constraints
w04	Invalid	x45	Patient sex missing or invalid
w05	Invalid	x46	Code missing accompanying proc
w06	Invalid admit/discharge date	x47	Code missing secondary dx
w07	Digit 4 not needed for date	x48	Invalid Patient Age
w08	Digit 4 missing for date	x49	Invalid Patient Sex
x01	HCPCS code is not valid	x50	Invalid Discharge Status
x02	HCPCS not valid for svc date	x51	Invalid Birthweight
x03	Conditionally bilateral	x52	Principal DX Invalid
x04	Inherently bilateral	x53	Principal DX Invalid
x05	Independently bilateral	x54	Principal DX Invalid
x06	Not bilateral	x55	Principal DX Invalid
x07	Unbundled Service	x56	Principal DX Invalid
x08	Unbundled Service	x57	Principal DX Invalid
x09	Unbundled Service	x58	Principal DX suggests surgery
x10	Unbundled Service	x59	All O R pxs are non-specific
x11	Unbundled Service	x60	Multiple Bilateral Procedures
x12	Unbundled Service	x61	Admit DX Invalid
x13	Unbundled Service	x62	Admit DX Age Conflict
x14	Unbundled Service	x63	Admit DX Sex Conflict
x15	Anes not reported separately	x64	Admit DX Age/Sex Conflict
x16	Anes not reported separately	x65	Admit DX suggests 2nd payer

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BMC HealthNet Plan – Remittance Advice Explanation Codes

x66	E code cannot be admit dx	y16	Invalid Occurrence Span Code
x67	Code cannot be admit dx	y17	Invalid Source of Admission
x68	Diagnosis - Invalid Diagnosis	y18	Invalid Type of Admission
x69	DX duplicate of Principle DX	y19	Line is a possible duplicate
x70	Diagnosis - Age Conflict	y20	Opt claim possible duplicate
x71	Diagnosis - Sex Conflict	y21	Inpat claim possible duplicate
x72	Diagnosis - Age/Sex Conflict	y22	Overlaps previous inpat claim
x73	Diagnosis suggests 2nd Payer	y23	Invalid diagnosis code
x74	DX duplicate to secondary dx	y24	Diagnosis and age conflict
x75	Procedure-Invalid Procedure	y25	Diagnosis and sex conflict
x76	Procedure-Sex Conflict	y26	Medicare as secondary payer
x77	Procedure n/c by Medicare	y27	E-Code cannot be used princial dx
x78	Open biopsy code	y28	Invalid HCPCS procedure
x79	Proc-Limited coverage proc	y29	Procedure and age conflict
x80	Procedure-Bilateral Code	y30	Procedure and sex conflict
x81	DOS to Units Discrepancy-Fac	y31	Non-Covered Service
x82	Units>1 for mod 50 bilat proc	y32	N/C Svc verification denial
x83	Incorrect Billing Modifier FB	y33	N/C Service for review
x84	No Rev cd 068X and proc 99291	y34	Questionable covered service
x85	Missing proc cd for device	y35	No addl payment by Medicare
x86	Possible duplicate claim	y36	Site of svc not incl in OPPS
x87	Invalid principal proc	y37	Service units out of range
x88	Statutory exclusion ICD-9 DX	y38	Multiple bilat PX w/o Mod 50
x89	Alternate	y39	Inappropriate bilateral proc
x90	Not found on table of valid DX	y40	Inpatient procedure
x91	4th/5th digit not needed	y41	Mutually Excl proc not allowed
x92	Invalid	y42	Mutually Excl proc not allowed
x93	Invalid patient admission date	y43	Component of comprehens proc not allowed
x94	Invalid DOA	y44	Comprehensive proc not allowed
x95	Invalid DOA missing digit 4	y45	Medical visit on same day
x96	Invalid Diagnosis	y46	Invalid HCPCS Modifier
x97	4th/5th digit not needed	y47	Invalid date
x98	Invalid	y48	Date out of OCE range
x99	Diagnosis invalid on Admit/Disc Date	y49	Invalid age
y01	Missing or Invalid Account ID	y50	Invalid sex
y02	Missing or invalid Service DT	y51	Only incidental svc reported
y03	Missing/invalid From/Thru DT	y52	Code not accepted by Medicare
y04	Invalid Condition Code	y53	Partial hosp for non-MH Dx
y05	Missing/invalid Pat Stat Code	y54	Insuff svcs for partial hosp
y06	Missing or invalid REV Code	y55	Part hospital same day as ECT
y07	Missing or invalid TOB Code	y56	Part hospital spans 3 or less
y08	Invalid Value Code	y57	Part hosp exceeds more 3 days
y09	Missing Principle diagnosis	y58	Part hosp exceeds more 3 days
y10	Missing Provider ID	y59	Only activity or OT provided
y11	Missing or invalid DOB	y60	Mental hlth svc on day of ET
y12	Patient gender empt/invalid	y61	Terminated bilat px or px w/ units > 1
y13	Blank Provider ID	y62	Inconsistent implant device/px
y14	Invalid ICD-9 Procedure Code	y63	Mutually exclusive procedure
y15	Invalid Occurrence Code	y64	Mut excl px allowed w/appr mod

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BMC HealthNet Plan – Remittance Advice Explanation Codes

y65	Comprehensive proc	z15	Duplicate Line by Provider
y66	Comprehensive proc	z16	Missing or Invalid DOB
y67	Invalid Revenue Code	z17	DOS to Units Discrepancy
y68	Mult visits	z18	Duplicate Claim
y69	Blood transfusion w/o product	z19	No Results
y70	Observ room rev code w/o svc	z20	Global Follow-Up by Provider
y71	Inpt separate proc is not paid	z21	Retained Code from Transfer
y72	Partial hosp Condition Code	z22	Post-Op Surgery by Provider
y73	Svc is not separately payable	z23	Unbundled Hx Px - Exclusive
y74	Revenue Code req HCPCS code	z24	Unbundled Hx Proc - Unbundle
y75	Svc on same day as inpat proc	z25	Hx Rebundle to Correct Code
y76	Non-covered based on statutory	z26	Retained Hx Code part of group
y77	Overlapping observation period	z27	Diagnosis Not Typical For Age
y78	Obs svc not separately payable	z28	Not a Freq Dx Code w/Procedure
y79	Obs svc only allowed with 13X	z29	Invalid Diagnosis Code
y80	Mult codes for same service	z30	Missing Diagnosis Code
y81	Not reportable for site of svc	z31	Anes X-Walk Individual Review
y82	Observ svc E&M reqs not met	z32	Nonspecific Diagnosis Code
y83	Observ svc E&M reqs not met	z33	Inappropriate Mod Combination
y84	G0263 only allowed with G0244	z34	Invalid Modifier Code
y85	Requires diagnosis code V707	z35	Dx Not Typical for Gender
y86	Mod CA w/more than one proc	z36	Modifier 26 Required
y87	Code billed only DME Carrier	z37	Assist Surgeon Pay Restriction
y88	Code not allowed	z38	Bilateral Adj Does Not Apply
y89	OT billed only on partial hosp	z39	Bundled Code - Medicare
y90	Act therapy svcs not payable	z40	Bundled Item or Service
y91	Rev not recog by Medicare	z41	Co-Surgeons Not Permitted
y92	Code requires manual pricing	z42	Document Assistant Surgeon
y93	Svc prior to FDA approval	z43	Document Co-Surgeon
y94	Svc prior to date of NCD	z44	Document Team Surgery
y95	Svc outside approval period	z45	Typical Daily Freq Exceeded
y96	CA mod reqs patient status 20	z46	Global Follow-Up by Provider
y97	Claim lacks req device code	z47	Inappropriate Mod - Medicare
y98	Service not billable to FI	z48	Injection Service - Medicare
y99	Incorrect billing of blood	z49	Non-Phys Service - Medicare
z01	Missing or Invalid Account ID	z50	Non-Covered Service - Medicare
z02	Anesthesia Crosswalk	z51	Not Valid for Medicare
z03	Anes Performed by Non-Anes Pro	z52	Mod Not Typical for Procedure
z04	Anesthesia Secondary Procedure	z53	Multiple Procedure Reduction
z05	Anes Secondary Procedure in Hx	z54	Physical Therapy Service
z06	Missing or Invalid DOS	z55	Post-Op Related Surg by Prov
z07	Bilateral Procedure Reduction	z56	Team Surgeons Not Permitted
z08	Missing or Bad POS	z57	Medicare UNB for History Line
z09	Anesthesia Crosswalk by Report	z58	Medicare Unbundled Scenario
z10	Procedure Not Typical for Age	z59	Medicare Ventilator Mgmt
z11	Deleted Procedure Code	z60	Not a Primary Diagnosis Code
z12	Invalid Procedure Code	z61	New Pt Code Billed for Est Pt
z13	Px Not Typical For Gender	z62	Missing Patient ID
z14	Records req./distinct/sep. service	z63	Invalid Prof Component Mod

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z64	POS Not Typical for Procedure	z82	Unbundled Hx Proc-Incidental
z65	Assist/Co/Team Surg Reduction	z83	Medicare bilat proc reduction
z66	Surgical Pre-Op E&M Procedure	z84	Medicare mult proc reduction
z67	Hx Surgical Pre-Op E&M Proc	z85	CA mod req pt status code 20
z68	Missing Provider ID	z86	Missing or Invalid Addtl Proc
z69	Missing Patient Gender	z87	Missing/Invalid Code to Code Dx
z70	Rebundle to Approp Procedure	z88	Missing/Invalid LCD Part B Dx
z71	Multiple Assistant Surgery	z89	Missing LCD Modifier
z72	Typically No Surgical Assist	z90	LCD Part B Dx Not in Prim Pos
z73	Timed Out	z91	Missing Req LCD Part B Prim Dx
z74	Dx may involve 3rd Party Liab	z92	Missing Req LCD Part B Sec Dx
z75	Transfer to Approp Procedure	z93	Missing Required LCD Part B Ter Dx
z76	Unbundled Proc - Exclusive	z94	Part B
z77	Unbundled Proc - Unbundle	z95	LCD Part B Typ Freq Exceeded
z78	Records req. / unlisted code	z96	LCD Part B Freq w/Dx Override
z79	Typically Cosmetic Procedure	z97	Missing Req LCD Place of Svc
z80	Investigational Procedure	z98	Proc Not Typical for Pt Sex
z81	Unbundled Proc - Incidental	z99	Inapprop Age for LCD Part B

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