MASSACHUSETTS

How to correct rejected claims

Quick tip

Using this quick tip

Your Provider Detail Advisory showed your claim rejected. What can you do to correct your claim? This quick tip gives you the most commonly used reject messages and suggestions on what you can do about them.

If you made an administrative error on a claim and need to send us a replacement claim, visit our Claim Submission page for details about the process.

To appeal a claim denial, please send a completed ***Request for Claim Review Form*** with all supporting documentation to:

Blue Cross Blue Shield of MA
Provider Appeals
P. O. Box 986065
Boston, MA 02298

For the *Reviews & Appeals* section of our *Blue Book* provider manual, log in to Provider Central and go to **Office Resources>Policies & Guidelines>Provider Manuals**.

Reject codes

Click the links below to go right to the information you need about your reject message.

B090, B092

Our reject code	HIPAA claim adjustment reason code	Message	What you need to know
B090 B092	29	The time limit for filing has expired.	You submitted the claim past the time it was due. We have a 90-day filing limit for all products except Indemnity (one year) and Veterans Administration (six years).

What can you do?

To appeal a claim that we rejected for exceeding the timely filing limit:

1. Fill out the *Request for Claim Review Form*
2. Send us the form, along with an accepted form of documentation (refer to the *Reviews & Appeals* section of the *Blue Book* provider manual).

E232, M105

Reject code	HIPAA code	Message	What you need to know
E232	96	Non-covered charges.	Based on the way you billed, this service is not covered under the member's plan.
M105		This service isn't covered. The member must pay the remaining balance. HIPAA standard adjustment reason code narrative: Non-covered charges.	

What can you do?

- Check your coding and the member's benefits.

E240, E281

Reject code	HIPAA code	Message	What you need to know
E240 E281	27	Expenses incurred after coverage terminated.	The member's coverage was terminated for the date of service submitted.

What can you do?

- Check the member's eligibility
  - Use Online Services, available through Provider Central in the eTools section.
  - For out-of-state (BlueCard) members, you also have the option to call **1-800-676-BLUE (2583)**.
- Verify with the member that the prefix and the ID # used for claim submission is correct for the date of service.
  - If a different ID number is provided, use electronic technologies, such as Online Services, to make sure it is valid for your date of service.
- Submit a new claim.

E375

Reject code	HIPAA code	Message	What you need to know
E375	97	This service is included in the overall care of the patient. There is no separate reimbursement and no patient balance. HIPAA standard adjustment reason code narrative: The benefits for this service are included in the payment/allowance for another service/procedure that has already be adjudicated.	We do not reimburse for this service because we consider it included in the overall care of the patient. It will deny whether submitted alone or with another procedure. There is no patient balance.

What can you do?

Refer to our General Coding and Billing payment policy.

E477

Reject code	HIPAA code	Message	What you need to know
E477	97	We cannot pay for this service because it does not meet our medical policy guidelines for the diagnosis reported. HIPAA standard adjustment reason code narrative: Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment.	The claim rejected because medical necessity criteria were not met.

What can you do?
Check our medical policies for medical necessity criteria. To appeal a claim, please send us a completed ***Request for Claim Review Form*** with all supporting clinical documentation.

E620

Reject code	HIPAA code	Message	What you need to know
E620	96	This routine service is not covered under the member's contract.	There may be an error in the diagnosis or procedure code reported for the member's date of service.

What can you do?
Check your coding. If there are errors, make the necessary corrections and send a replacement claim.

F918

Reject code	HIPAA code	Message	What you need to know
F918	96	Your claim rejected because you are required to use our technology for claims, payment, or other administrative purposes. Please register today. Once registered, you'll need to resubmit your claim. For more information, go to **bluecrossma.com/provider**. HIPAA standard adjustment reason code narrative: Non-covered charge(s).	Our policy requires providers to register for e-payment with Payspan. You cannot bill the member for this service.

What can you do?
- Register for e-payment with Payspan at payspanhealth.com. You can find out more about Payspan and how to register for e-payment in the eTools section of Provider Central.
- Once you've successfully completed the Payspan registration and received your "congratulations" confirmation email, it can take up to 10 business days for our system to refresh.
- Resubmit the claim for processing.

M296

Reject code	HIPAA code	Message	What you need to know
M296	62	Payment denied/reduced for absence of or exceeded, pre-certification/authorization.	When referrals and authorizations are required, you must get them before services are rendered. This allows claims to process seamlessly and helps avoid unnecessary appeals. Always request the appropriate timeframe and number of visits needed.

What can you do?

Primary care providers can enter retroactive referrals and authorizations 90 days from the date of service. We will not accept retroactive referrals and authorizations beyond that date.

For additional information about referrals and authorizations, log in to Provider Central and go to:

- **Office Resources>Policies & Guidelines>**Referrals
- **Office Resources > Policies & Guidelines>**Provider Manuals.

P141

Reject code	HIPAA code	Message	What you need to know
P141	204	We cannot pay this service because the service you performed or item you provided is not part of your contract. HIPAA standard adjustment reason code narrative: This service/equipment/drug is not covered under the patient's current benefit plan.	The service you billed is not listed on your fee schedule.

What can you do?

Verify the fee schedule for the provider rendering the service. You can get the fee schedule on Provider Central by clicking **Office Resources>Billing & Reimbursement>Fee Schedules**.

Q334

Reject code	HIPAA code	Message	What you need to know
Q334	350	These charges cannot be processed because a detailed description of the service is missing or invalid. HIPAA standard adjustment reason code narrative: Missing/incomplete/ invalid description of service for a not otherwise classified (NOC) code or for an unlisted/by report procedure.	We need a description of the service to process your claim.

What can you do?
You can appeal your claim by sending us a completed ***Request for Claim Review Form***. Attach the description of the service. If you are appealing a medication's NOC code, please include the NDC number.

Q708, Q918

Reject code	HIPAA code	Message	What you need to know
Q708 Q918	130	Benefits for these services are not covered by the member's health plan. Please call 1-800-676-2583 to check the member's benefits. HIPAA standard adjustment reason code narrative: Consult plan benefit documentation/ guidelines for information about restrictions for this service.	The service is not covered by the member's plan as billed.

What can you do?
Verify the member's benefits:

- For Blue Cross Blue Shield of Massachusetts members, use Online Services in the eTools section of Provider Central
- For out-of-state (BlueCard) members, call **1-800-676-BLUE (2583)**.

If the member *does* have benefits, you'll need to request an appeal. Send us a completed ***Request for Claim Review Form*** with any supporting documentation. If you verified the member's benefits by calling, please include a reference number for the call, the date you called, and the person you spoke with.

If the member *does not* have benefits they are responsible for the balance.

Q903, Q922

Reject code	HIPAA code	Message	What you need to know
Q903 Q922	55 50	This service isn't covered because it isn't medically necessary. For individual consideration, please send clinical documentation to BCBSMA, PO Box 986065, Boston, MA 02298-6065. HIPAA standard adjustment reason code narrative: Procedure/treatment/ drug is deemed experimental/ investigational or not medically necessary by the payer.	Your claim rejected because it didn't meet medical necessity criteria.

What can you do?
Check our medical policies for medical necessity criteria. To appeal a claim, please send us a completed ***Request for Claim Review Form*** with all supporting clinical documentation.

Q923

Reject code	HIPAA code	Message	What you need to know
Q923	31	The patient cannot be identified from the information you submitted. Please check the member information and ID number and submit a new claim. You may verify eligibility by calling 1-800-676-2583. HIPAA standard adjustment reason code narrative: Patient cannot be identified as our insured.	You'll need to verify the member's information.

What can you do?

- Verify eligibility: patient's name, date of birth, gender, and relationship to the subscriber.
  - Use Online Services available through Provider Central (see eTools section).
  - For out-of-state members, you also have the option to call **1-800-676-BLUE (2583)**.

- Verify that the prefix and the ID # used for the claim submission is correct for the date of service.
  - If another ID number is provided, use electronic technology to verify that it is valid for your date of service.
  - Submit a new claim.

Q319, Q980

Reject code	HIPAA code	Message	What you need to know
Q319 Q980	243	Referral or authorization is required, and no referral or authorization is on file. HIPAA standard adjustment reason code narrative: Services not authorized by network/primary care providers.	Always verify referral and authorization guidelines. For HMO New England members, you'll need to verify referral and authorization guidelines with the state where the member's primary care provider is located.

What can you do?

This reject message is typically used for BlueCard claims (the member has another Blue Cross plan). For pre-certification or prior authorization information:

- Blue Cross Blue Shield pre-certification, pre-authorization information

BlueCard plan information is on Provider Central at **Office Resources>Plans & Products>BlueCard and Out-of-Area Programs**.

U246

Reject code	HIPAA code	Message	What you need to know
U246	56	We cannot pay for this service because it does not meet our Medical Technology Assessment criteria OR our Medical Policy guidelines for the diagnosis reported. We have notified the Member that he or she is not responsible for payment on this service unless you told the Member that it was not covered before performing the service; otherwise, there is no Member balance.	We review our medical policies throughout the year and may change coverage for diagnostic technologies based on that review. Please check our medical policies—including our *Medical Technology Assessment Guidelines* and our *Medical Technology Assessment Non-covered Services*—periodically to ensure that you have the most recent policy information.

What can you do?
Verify if the procedure reported meets *Medical Technology Assessment Guidelines* for the diagnosis. To request a medical necessity review, please send us a completed ***Request for Claim Review Form*** with all supporting clinical documentation.

U301, U302

Reject code	HIPAA code	Message	What you need to know
U301 (system-generated) U302 (manual review/reject)	18	Duplicate claim/service	The claim we received matches a claim that (a) is currently in process, or (b) has previously paid, or (c) has been previously denied.

What can you do?
Before submitting a second claim, allow 45 days from our receipt date and then check claim status.

U714, U715, U717, U719

Reject code	HIPAA code	Message	What you need to know
U714 U715 U717 U719	97	Payment for this procedure is included with the payment of another procedure performed on the same day. HIPAA standard adjustment reason code narrative: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	The procedure billed is related to another procedure performed by the same provider for the same date of service.

What can you do?
Resubmit your claim with a modifier if it meets CPT® or HCPCS industry-standard modifier requirements. Modifiers allow for accurate reporting of services and claim processing, and can affect payment.

Refer to our CPT and HCPCS Modifiers payment policy.

X023, X024

Reject code	HIPAA code	Message	What you need to know
X023 X024	20	A complete description of the procedures performed is necessary to appropriately process this claim. HIPAA standard adjustment reason code narrative: Missing/ incomplete/ invalid HCPCS.	To process your claim, we need a description of this service.

What can you do?
To appeal this denial, please send us a completed ***Request for Claim Review Form*** with a description of the service. If you are appealing a not otherwise classified (NOC) code for a medication, please include the NDC number.

X105, X055

Reject code	HIPAA code	Message	What you need to know
X105 X055	16	We cannot process this claim until we receive additional information from the subscriber. We will adjust the claim once our information is complete.	Due to incomplete Medicare information in our enrollment files, the subscriber must contact us at **1-800-839-8991**. *This is a subscriber responsibility.* Once updated, we will manually adjust all claims.

What can you do?
Advise the member to contact us with their Medicare information or they will receive a bill.

X118

Reject code	HIPAA code	Message	What you need to know
X118	31	Claim denied as member cannot be identified as our insured	These messages often appear when there is a typo in a field.

What can you do?
If within timely filing guidelines, correct the claim and resubmit electronically. Or, you may request a claim adjustment by completing a *Request for Claim Review Form*.

To minimize these error messages, verify member eligibility at the time services are rendered. NOTE: the first three characters of the ID # are letters. Be careful not to substitute numbers for letters. For example, be sure to use the letter "O," not the number zero, when referencing prefix "AZO."

X419

Reject code	HIPAA code	Message	What you need to know
X419	208	The billing Provider NPI and Tax ID combination submitted on this claim does not match the information in our files. Please verify the NPI and TIN and rebill the claim with corrected information. HIPAA standard adjustment reason code narrative: NPI denial, not matched.	The NPI and tax ID on the claim do not match our files.

What can you do?

- Check the tax ID and NPI that you used on your claim.
- If you notice a discrepancy after verifying this information, please contact Network Management and Credentialing Services at **1-800-316-BLUE (2583)** to make necessary changes. Once updated, you'll need to submit a new claim.
- **Important:** Updating your information in Online Services (Direct Data Entry) does not update our provider files. If you changed your Tax ID Number from your Social Security number to an Employer Identification number in Online Services, you must also submit a *Standardized Provider Information Change Form*.