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 common 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:

Medical appeals	Dental Appeals
Blue Cross Blue Shield of Massachusetts Provider Appeals PO Box 986065 Boston, MA 02298	Blue Cross Blue Shield of Massachusetts Process Control PO Box 986010 Boston, MA 02298

For 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	E620	M296	Q360	Q918	U302	X024
B092	F701	M628	Q646	Q922	U714	X055
E240	F703	P141	Q678	Q923	U715	X368
E281	F704	Q319	Q708	Q980	U717	X419
E375	F706	Q334	Q903	U246	U719	
E477	F918	Q353	Q910	U301	X023	

B090, B092, Q678

Our reject code	HIPAA claim adjustment reason code	Message	What you need to know
B090 B092 Q678	29	This claim was submitted after the filing deadline. HIPAA standard adjustment reason code narrative: 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).

E240, E281

Reject code	HIPAA code	Message	What you need to know
E240 E281	31	Policy not active for the date of service submitted. HIPAA standard adjustment reason code narrative: Patient cannot be identified as our insured.	The member's coverage was not active for the date of service submitted.

What can you do?

1. Check the member's eligibility.
    - Use ConnectCenter, available through Provider Central in the eTools section (log in required).
    - For out-of-state (BlueCard) members, you also have the option to call **1-800-676-BLUE (2583)**.
    - If you verify that the information matches what was submitted on your claim, call Provider Service with the reference number for the call, the date you called, and the name of the person you spoke with.
2. 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 ConnectCenter, to make sure it is valid for your date of service.
3. Submit a new claim.

E375

Reject code	HIPAA code	Message	What you need to know
E375	97	This service is not reimbursed/separately reimbursed due to payment policy. HIPAA standard adjustment reason code narrative: The benefits for this service are included in the payment/allowance for another service/procedure that has already been 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: payment policy: Log in to Provider Central and go to: **Office Resources>Policies & Guidelines>Payment Policies**.

E477

Reject code	HIPAA code	Message	What you need to know
E477	97	This service isn't covered based on our medical policy guidelines for the diagnosis submitted. 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	Benefits for these services are not available under the terms of this plan when ordered/performed by a doctor of chiropractic medicine. HIPAA standard adjustment reason code narrative: Non-covered charges.	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.

F701

Reject code	HIPAA code	Message	What you need to know
F701	95	Blue Cross Blue Shield of Massachusetts does not allow global billing for this service. Please verify coding and submit a replacement claim. You may not bill the patient. HIPAA standard adjustment reason code narrative: This provider type/provider specialty may not bill this service.	Based on our billing guidelines, you cannot bill services globally. You must split them into professional and technical components.

What can you do?
Check our payment policies. Log in to Provider Central and go to: **Office Resources>Policies & Guidelines>Payment Policies**. Then, review your coding to make the necessary corrections and send a replacement claim.

F703, F704, F706

Reject code	HIPAA code	Message	What you need to know
F703 F704 F706	95	Based on our payment policy guidelines, you are not eligible to be reimbursed for this service. HIPAA standard adjustment reason code narrative: This provider type/provider specialty may not bill this ser vice.	The billing provider on this claim is not credentialed with Blue Cross to perform the professional or technical component that is being billed.

What can you do?
Check our payment policies. Log in to Provider Central and go to: **Office Resources>Policies & Guidelines>Payment Policies**. Then, review your coding to 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 not registered with Payspan. Once registered and files are updated, you'll need to send a new 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?

1. 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.
2. 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.
3. Once the 10 business days have passed, please submit a new claim.

M296

Reject code	HIPAA code	Message	What you need to know
M296	197	This claim denied because the required referral, authorization, notification, or prior approval was not obtained. The member is not responsible unless they signed a waiver assuming responsibility for this date of service prior to the service. HIPAA standard adjustment reason code narrative: Precertification/authorization/notification/pre-treatment absent.	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. Once obtained, submit a replacement claim.

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**

M628

Reject code	HIPAA code	Message	What you need to know
M628	242	We cannot pay this claim because the service was not rendered by a network provider. HIPAA standard adjustment reason code narrative: Services not provided by network/primary care providers.	This member may have specific benefits that only allow them to see certain provider networks, for example: Atrius Health.

What can you do?

Verify the member's benefits:

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

To appeal, you must verify the member's benefits by calling their plan. If the member *does* have benefits, send us a completed *Request for Claim Review Form* with any supporting documentation. Please include a reference number for the call, the date you called, and the name of the person you spoke with.

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

P141

Reject code	HIPAA code	Message	What you need to know
P141	170	We cannot pay this service because the service you performed or item you provided is not part of your contract with us. HIPAA standard adjustment reason code narrative: Payment is denied when performed/billed by this type of provider.	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. First, log in, then click **Office Resources>Billing & Reimbursement>Fee Schedules.**

- Reminder for CMHC providers: If the service is listed on your fee schedule, please verify the appropriate modifier has been billed.

Q334

Reject code	HIPAA code	Message	What you need to know
Q334	16	These charges cannot be processed because a detailed description of the service is missing or invalid. HIPAA standard adjustment reason code narrative: Claim/service lacks information or has submission/billing errors.	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 not otherwise classified (NOC) code, please include the NDC number.

Q353, Q360

Reject code	HIPAA code	Message	What you need to know
Q353 Q360	16	Final benefit determination cannot be made until we receive complete medical records. HIPAA standard adjustment reason code narrative: Claim/service lacks information or has submission/billing errors.	The member's plan needs medical records to determine if the services billed are payable based on benefits.

What can you do?
You should have received a formal medical record request letter from us. Return it to the address listed on the letter with the requested medical records attached. We will then forward it to the member's out-of-state (BlueCard) plan for review.

Q646

Reject code	HIPAA code	Message	What you need to know
Q646	16	Information has been requested from the member. If the requested information is returned by the member, the claim will be reconsidered. Until then, the member is responsible for the balance. HIPAA standard adjustment reason code narrative: Claim/service lacks information or has submission/billing errors.	The member's plan needs specific information from the member to process claims.

What can you do?
You cannot appeal this denial. It is the member's responsibility to return the requested information to their plan. Until they do, you may bill the member. Once the plan receives the information they need, claims will be automatically adjusted.

Q708, Q918

Reject code	HIPAA code	Message	What you need to know
Q708 Q918	96	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: Non-covered charges.	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 ConnectCenter in the eTools section of Provider Central.
- For out-of-state (BlueCard) members, call **1-800-676-BLUE (2583)**.

To appeal, you must verify the member's benefits by calling their plan. If the member *does* have benefits, send us a completed *Request for Claim Review Form* with any supporting documentation. Please include a reference number for the call, the date you called, and the name of 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 the member's plan's medical necessity criteria.

What can you do?
Check the member's out-of-state (BlueCard) plan's medical policies. To appeal a claim, please send us a completed *Request for Claim Review Form* with all supporting clinical documentation so that we can forward it to the plan for review.

Q923

Reject code	HIPAA code	Message	What you need to know
Q923	31	We can't identify the patient from the information submitted. Please verify eligibility by calling **1-800-676-2583** or using eTools at **Bluecrossma.com/provider**. 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?

1. Verify eligibility: patient's name, date of birth, gender, and relationship to the subscriber.
   - Use ConnectCenter, available through Provider Central (see eTools section).
   - For out-of-state members, you also have the option to call **1-800-676-BLUE (2583)**.
   - If you verify that the information matches what was submitted on your claim, call Provider Service with the reference number for the call, the date you called, and the name of the person you spoke with.
2. 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	Claim denied because required pre-authorization is not 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 an out-of-state Blue Cross plan). For pre-certification or prior authorization information: Blue Cross Blue Shield pre-certification, pre-authorization information. Once obtained, call Provider Service with the referral/authorization number, or appeal with a hard copy of the authorization.

BlueCard plan information is on Provider Central at **Patient 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 OR the diagnosis is not included in the collaborative oncology incentive program. HIPAA standard adjustment reason code narrative: Procedure/treatment has not been deemed 'proven to be effective' by the payer.	Please check our medical policies periodically. We review them throughout the year and may change coverage for diagnostic technologies based on that review.

What can you do?
To request a medical necessity review, please send us a completed *Request for Claim Review Form* with all supporting clinical documentation.

U301, U302, Q910

Reject code	HIPAA code	Message	What you need to know
U301 (system-generated) U302 (manual review/reject) Q910 (BlueCard)	18	According to our records, we have already processed a claim for this service. HIPAA standard adjustment reason code narrative: Payment for this claim/service may have been provided in a previous payment.	The claim we received matches a claim that (a) is currently in process, (b) has previously paid, or (c) has previously denied.

What can you do?
Allow 45 days from our receipt date and then check claim status. If it is not a duplicate for medically necessary reasons, send us a completed *Request for Claim Review Form* with all supporting clinical documentation.

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, usually indicated by message code U726.

What can you do?
Submit a replacement 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: Log in to Provider Central and go to: **Office Resources>Policies & Guidelines>Payment Policies**.

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.

X055

Reject code	HIPAA code	Message	What you need to know
X055	16	We requested that the member call us with their Medicare eligibility information at **1-800-839-8991**. HIPAA standard adjustment reason code narrative: Claim/service lacks information or has submission/billing errors.	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.

X368

Reject code	HIPAA code	Message	What you need to know
X368	16	Additional information is required before we can process this claim. Please send clinical notes to: Blue Cross Blue Shield of Massachusetts, PO Box 986065, Boston, MA 02298-6065. HIPAA standard adjustment reason code narrative: Claim/service lacks information or has submission/billing errors.	To process your claim, we need supporting clinical documentation.

What can you do?
Please send us a completed *Request for Claim Review Form* with clinical documentation that supports the service.

X419

Reject code	HIPAA code	Message	What you need to know
X419	208	Your NPI and Tax ID combination do not match the information we have on file. Please verify the NPI/TIN and submit a new claim. 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?

1. Check the tax ID and NPI that you used on your claim.
2. 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, or email providercredenroll@bcbsma.com. Once updated, you'll need to submit a new claim.

Important: Updating your information in ConnectCenter (**Admin>Provider Management**) does ***not*** update our provider files. If you changed your Tax ID number from your Social Security number to an Employer Identification number in ConnectCenter, you must also submit a *Standardized Provider Information Change Form*.