



**BlueCross BlueShield
of Mississippi**

Committed to a Healthier Mississippi.

Error / Reject Message Reference Manual *FOR*

Electronic Submission of Professional Claims (837P)

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INTRODUCTION

Blue Cross & Blue Shield of Mississippi provides this manual as a service to providers participating in the Plan's Physician Electronic Submission of Claims (PESC) system. It is intended to be used as a guide for the resolution of the various errors and reject messages generated by the PESC system when professional claims are transmitted electronically to the Plan.

The **BLUE SHIELD PHYSICIAN ESC ERROR MESSAGES** provide a short description and corrective action(s) necessary for the resolution of each error.

If further help is needed in resolving errors, contact:

EDI Systems Support at 1-800-826-4068

Questions and comments regarding the **BLUE SHIELD** portions of this manual can be addressed to:

Blue Cross & Blue Shield of Mississippi
ATTENTION: EDI Systems Support
P. O. Box 1043
Jackson, MS 39205-1043

If you are a Network Provider of Blue Cross & Blue Shield of Mississippi, you can obtain updated versions of this manual by logging on to <https://www.myAccessBlue.com> and clicking on Download Forms on the home page. Select CMS1500 Error Reject Reference Manual and a PDF version will be downloaded to your system for printing or viewing.

ERROR NUMBER	DESCRIPTION	CORRECTIVE ACTION
001	PROVIDER NUMBER	<p>BC, MR, MC, CM</p> <p>NPI numbers must be valid according to Fox Systems, the NPI Enumerator contracted by CMS.</p> <p>BC</p> <p>NPI or W-9 information has not been established in our system and/or does not match existing provider identifier information in our system. Please contact the BCBSMS Provider Administration department at 601-664-4618 to establish and/or verify your NPI and W-9 information.</p>
002	PATIENT ACCOUNT NUMBER	<p>MR</p> <p>Patient account number is required</p> <p>Patient account number cannot start with a space or asterisk (*)</p>

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ERROR NUMBER	DESCRIPTION	CORRECTIVE ACTION
003	INSURANCE I.D. NUMBER	<p>BC</p> <p>Must include all alpha prefixes.</p> <p>Must be left justified with no embedded blanks, spaces or special characters.</p> <p>MR</p> <p>Must be left justified with no embedded blanks, spaces or special characters.</p> <p>MC</p> <p>Must be left justified with no embedded blanks, spaces or special characters.</p> <p>CM</p> <p>If PAYOR NUMBER = 74223, 37060 or 34097 the INSURANCE ID NUMBER must be 11 characters.</p> <p>If PAYOR NUMBER = 95378 the INSURANCE ID NUMBER must be 8 OR 11 characters. 1-7 may only contain 0-9 and 8 only A-Z OR 1 may contain A-Z or 0-9 and 11 may only contain a value o 0-9.</p> <p>If PAYOR NUMBER = 38253 the INSURANCE ID NUMBER must be 9, 10 or 11 characters.</p>
005	PATIENT LAST NAME	<p>PATIENT LAST NAME must be in the correct position and all alphabetic characters.</p>
005	PATIENT FIRST NAME	<p>PATIENT FIRST NAME must be in the correct position and all alphabetic characters.</p>
006	PATIENT BIRTH DATE	<p>BC and MC</p> <p>Patient BIRTH DATE cannot exceed 100 years.</p> <p>Patient BIRTH DATE cannot exceed current date.</p> <p>CM and MR</p> <p>Patient BIRTH DATE cannot exceed current date.</p>

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007	PATIENT SEX	PATIENT SEX valid values are: M = Male F = Female
008	PATIENT RELATIONSHIP	BC, MR and CM PATIENT RELATIONSHIP Valid values are: 18 SE = SELF 01 SP = SPOUSE 19 CH = CHILD 21 UNKNOWN
009	DATE FIRST CONSULTED	BC and CM DATE FIRST CONSULTED Must be in CCYYMMDD format when transmitted. Cannot exceed Current Date.
010	ASSIGNMENT OF BENEFITS	BC and CM ASSIGNMENT OF BENEFITS CLM08 Valid values are: Y = YES N = NO MR ASSIGNMENT OF BENEFITS Valid values are: Y = YES N = NO A = Assigned (same as 'Y') CLM07
012	ACCIDENT RELATED	BC and CM - ACCIDENT RELATED Valid values are: AA = Auto OA = Other EM = Employment

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		<p>CM.</p> <p>Must be left justified with no embedded punctuation.</p> <p>The diagnosis must fall within the code's effective dates for this procedure.</p> <p>Serious Reportable Event (SRE) diagnosis codes (E876.5, E876.6, and E876.7) will not be accepted on claims from network providers with dates of service on or after 1/1/10. Under no circumstances will there be reimbursement for SREs, and the member will be held harmless for any charges relating to the SRE.</p>
020	SECONDARY DIAGNOSIS CODE	<p>SECONDARY DIAGNOSIS CODES If present must be valid according to ICD9-CM.</p> <p>Must be left justified with no embedded punctuation.</p> <p>The diagnosis must fall within the code's effective dates for this procedure.</p> <p>Serious Reportable Event (SRE) diagnosis codes (E876.5, E876.6, and E876.7) will not be accepted on claims from network providers with dates of service on or after 1/1/10. Under no circumstances will there be reimbursement for SREs, and the member will be held harmless for any charges relating to the SRE.</p> <p>An Auto accident indicator requires an E diagnosis code in the defined range: E810 - E8169 E8190 - E8199 E8220 - E8239 E8250 - E8259 E8263 - E8279 E8264 E8299 E929 - E9290</p> <p>For State of Mississippi contracts, a SECONDARY DIAGNOSIS CODE must be present if the primary diagnosis is V829.</p>
021	TERTIARY DIAGNOSIS CODE	<p>TERTIARY DIAGNOSIS CODE</p> <p>If present must be valid according to ICD9-CM.</p>

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		<p>Must be left justified with no embedded punctuation.</p> <p>The diagnosis must fall within the code's effective dates for this procedure.</p> <p>Serious Reportable Event (SRE) diagnosis codes (E876.5, E876.6, and E876.7) will not be accepted on claims from network providers with dates of service on or after 1/1/10. Under no circumstances will there be reimbursement for SREs, and the member will be held harmless for any charges relating to the SRE.</p>
022	OTHER DIAGNOSIS CODE	<p>OTHER DIAGNOSIS CODE</p> <p>If present must be valid according to ICD9-CM.</p> <p>Must be left justified with no embedded punctuation.</p> <p>The diagnosis must fall within the code's effective dates for this procedure.</p> <p>Serious Reportable Event (SRE) diagnosis codes (E876.5, E876.6, and E876.7) will not be accepted on claims from network providers with dates of service on or after 1/1/10. Under no circumstances will there be reimbursement for SREs, and the member will be held harmless for any charges relating to the SRE.</p>
023	<p>REFERRING PHYSICIAN LAST NAME</p> <p>REFERRING PHYSICIAN ID</p>	<p>REFERRING PHYSICIAN LAST NAME</p> <p>Must be left justified and all alphabetic characters.</p> <p>MR If procedure code is in the range 70000-89999, 93000-93350, 93720-94620, 94680-94799, 95805-95999, 99241-99275 the ordering physician AND referring physician UPIN numbers are required..</p> <p>If procedure code is in the range 90600-90654, REFERRING PHYSICIAN LAST NAME is required.</p>
024	MAMMOGRAPHY CERT NUMBER	MR

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ERROR NUMBER	DESCRIPTION	CORRECTIVE ACTION
		A mammography certification number is required if procedure codes '76091' or '76092' are entered.
025	<p>EPSDT (Early And Periodic Screening Diagnosis And Treatment)</p> <p>SPECIAL PROGRAM INDICATOR</p>	<p>MC</p> <p>Valid values are: Y = Yes or leave blank</p> <p>SPECIAL PROGRAM INDICATOR Valid values are: 01 – EPSDT & Child Health Assessment Program (CHAP) 02 - Physically Handicapped Children’s Program 03 - Special Federal Funding 05 – Disability 07 - Induced Abortion – Danger to Life 08 - Induced Abortion - Victim Rape/Incest 09 - Medicaid EPSDT</p>
026	FAMILY PLANNING	<p>BC, MR and MC</p> <p>FAMILY PLANNING Valid values are: Y = Yes</p>
027	<p>BC</p> <p>CHAMPUS STATUS</p> <p>MC</p> <p>PRIOR AUTHORIZATION NUMBER</p> <p>MR</p> <p>HOSPICE IDENTIFICATION NUMBER</p>	<p>BC</p> <p>CHAMPUS STATUS Valid values are: A = Active Duty D = Deceased R = Retired</p> <p>MC</p> <p>PRIOR AUTHORIZATION NUMBER Must be 8 digits.</p> <p>MR</p> <p>If entered, must be 6 digits.</p>

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035	HOSPITALIZATION ADMISSION	<p>BC Cannot be prior to first date of service on claim.</p> <p>MR Required when place of service is inpatient hospital</p>
036	HOSPITALIZATION DISCHARGE DATE	<p>BC and CM</p> <p>DISCHARGE DATE must be in CCYYMMDDYY format. (Century-Year-Month-Day).</p> <p>Cannot exceed current date.</p> <p>REQUIRED for Champus on inpatient claims.</p>
037	FACILITY STATE	<p>BC and CM</p> <p>The 2 digit alphabetic State Code must be valid. (Validate by Exhibit A)</p>
038	DATE ABLE RETURN WORK	<p>BC and CM</p> <p>Must be in CCYYMMDD format. (Century-Month-Day-Year)</p>
039	TOTAL DISABILITY FROM DATE	<p>BC and CM</p> <p>Must be in CCYYMMDD format. (Century-Year-Month-Day)</p>
040	TOTAL DISABILITY THROUGH DATE	<p>BC and CM</p> <p>Must be in CCYYMMDD format. (Century-Year-Month-Day)</p>
041	PARTIAL DISABILITY FROM DATE	<p>BC and CM</p> <p>Must be in CCYYMMDD format. (Century-Year- Month-Day).</p>
042	PARTIAL DISABILITY THROUGH DATE	<p>BC and CM</p> <p>Must be in CCYYMMDD format. (Century-Year- Month-Day)</p>

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043	<p>LINE ITEM UNITS</p> <p>OR</p> <p>INVALID PAYOR ID</p>	<p>BC Units per Claim cannot exceed 34. There are exceptions for injections and chemotherapy.</p> <p>MC Payer id for Medicaid line must be 77032</p> <p>MD Payer id for Medicare line must be 00512</p> <p>CM Payer id must be on the most current NEIC Medical Payer list.</p>
044	ACCIDENT STATE	<p>CM The state in which the auto accident occurred is required for this payer.</p>
045	PAYOR ADDRESS	<p>Must be present.</p> <p>Payer state and zip combination must be valid according to the US Postal Service website.</p>
046	INSURANCE TYPE CODE	<p>Must be valid</p> <p>MP=Medicare Primary MG=Medigap Policy SP=Supplemental policy IP=Individual Policy PP=personal Payment GP=Group Policy LT=Litigation AP=Auto Insurance Policy LD=Long Term Policy OT=Other</p> <p>The following codes must only be used if the secondary is Medicare</p> <p>12=Working Aged Beneficiary /Spouse with group health plan</p>

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		13=ESRD Beneficiary in the 12-month coordination period with an employer's group health plan 14=No fault insurance include auto 15=Worker's compensation 16=PHS or other federal agency 41=Black lung 42=VA 43=Disabled beneficiary under age 65 with LHGP 47=Any liability insurance Must be blank if Medicare B is the only Insurance
047	ASSISTANT SURGEON	BC If any procedure modifier = 80 or 82, then the same procedure <u>cannot</u> be filed on the same claim <u>without</u> modifier 80 or 82.
048 - 051	ADDITIONAL COB INFORMATION IS REQUIRED	Our records show that the patient has indicated they have other insurance coverage which is primary. Please provide the following information: Other Insured Name Other Insured Policy Number Other Insured Employer Other Insured Insurance Plan or Company Name
052	PATIENT SEX/AGE CONFLICTS WITH DIAGNOSIS	Primary Diagnosis - Patient sex must match diagnosis code sex and patient age must fall within diagnosis code low/high age
053	PATIENT SEX/AGE CONFLICTS WITH DIAGNOSIS	Secondary Diagnosis - Patient sex must match diagnosis code sex and patient age must fall within diagnosis code low./high age
054	PATIENT SEX/AGE CONFLICTS WITH DIAGNOSIS	Tertiary Diagnosis - Patient sex must match diagnosis code sex and patient age must fall within diagnosis code low./high age
055	PATIENT SEX/AGE CONFLICTS WITH DIAGNOSIS	Fourth Diagnosis - Patient sex must match diagnosis code sex and patient age must fall within diagnosis code low./high age
057	NPI NOT SUBMITTED ON CLAIM	Required by Medicaid November 23, 2007
101	FROM DATE OF SERVICE	Cannot exceed current date. Cannot be over 18 months.
102	THROUGH DATE OF SERVICE	Cannot exceed current date.

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ERROR NUMBER	DESCRIPTION	CORRECTIVE ACTION
		Must equal "From Date of Service" if procedure code is 99070.
103	PLACE OF TREATMENT/SERVICE	<p>BC, MR, MC and CM</p> <p>Must be valid PLACE OF TREATMENT / SERVICE code.</p> <p>BC FROM DATE OF SERVICE and THROUGH DATE OF SERVICE must be equal for PLACE OF TREATMENT/SERVICE '11'.</p>
104	PROCEDURE CODE	<p>BC, CM and MR</p> <p>Must be valid PROCEDURE CODE according to the CURRENT CPT MANUAL.</p> <p>Service from / to dates must fall within HCPC procedure effective/cancel dates</p> <p>CHAMPUS</p> <p>Procedures 90800-90900 require modifier '29'.</p>
105	MODIFIER	<p>BC</p> <p>Must be a valid MODIFIER according to the CURRENT CPT MANUAL. And valid for the procedure code.</p> <p>Durable Medical Equipment codes (E0001-E9999 or K0001-K9999) require either a Rental (RR) or Purchase (NU) MODIFIER.</p> <p>CM and MR</p> <p>Must be a valid MODIFIER according to the CURRENT CPT MANUAL</p>
106	DIAGNOSIS CODE INDICATOR	<p>BC, MR and MC</p> <p>Must be a valid DIAGNOSIS CODE INDICATOR of the following values:</p> <p>1 = PRIMARY DIAGNOSIS 2 = SECONDARY DIAGNOSIS 3 = TERTIARY DIAGNOSIS 4 = OTHER DIAGNOSIS</p> <p>CM</p>

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		Additionally - 5 = No Diagnosis Applies Ambulance Claims Only
107	CHARGES	BC, CM, and MR Must be numeric and not equal to zero. MC Following the designation of 90471 and 90472 with an EP modifier, the provider must also bill appropriate vaccine code(s) in the CPT 90476 through 90749 range with an EP modifier and show a (\$00.00) charge.
108	DAYS OR UNITS	BC, CM, MR and MC Must be numeric and not equal to zero Cannot be more than 999
109	TIME - ANESTHESIA/OXYGEN MIN PURCHASED SERVICE INDICATOR PURCHASED SERVICE CHARGE PURCHASED SERVICE PROVIDER ID PURCHASED SERVICE PROVIDER NAME	BC, CM, MR and MC Must be reported in minutes. MR Purchased Service Indicator values are 'Y' or 'N'. If the indicator is 'Y', then the Purchased Service Charge, Purchased Service Provider ID and Purchased Service Provider Name must be completed.
110	OTHER INSURANCE ALLOWED	BC Maximum of 7 numeric positions with no decimals. OR BC records show that this is a secondary policy, therefore the claim must have Other Insurance Allowed or a Denied reason (COB on CMS-1500). Denied Reasons: 96 = not a covered service 31 = primary policy cancelled
111	OTHER INSURANCE PAID	BC

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		<p>If Blue Cross determines this is a secondary Policy, and Other Insurance Allowed amount is submitted, then either the Other Insurance Paid or Other Insurance Deductible must also be submitted</p> <p>Maximum of 7 numeric positions with no decimals.</p>
112	<p>OTHER INSURANCE DEDUCTIBLE</p> <p>INDEPENDENT LAB CHARGES</p>	<p>BC Maximum of 7 numeric positions with no decimals.</p> <p>CM and MR Must be numeric and not equal to zero.</p>
113	INVALID PROCEDURE / DIAGNOSIS CODE	Vaccine covered by Federal Government and should not be billed to BCBSMS. Only the administration component should be billed (and any procedures performed during the visit as applicable.)
114	PERFORMING PROVIDER ID	<p>CM</p> <p>For CHAMPUS claims, the Champus rendering provider number must be entered per line item.</p>
115	CLIAM NUMBER	<p>MR</p> <p>If PROCEDURE CODE is 80000-89999 or G0026, G0027, or G0101 and the PLACE OF SERVICE is office (11), the CLIA number is required.</p>
116	FACILITY ZIP CODE REQUIRED	<p>BC</p> <p>If place of service is '41' or '42' (ambulance), a zip code for the pick-up location must be entered.</p>
117	<p>OTHER INSURANCE INFORMATION REQUIRED (Paid, Allowed, Denied Reason, etc.)</p>	<p>BC</p> <p>When records indicate other insurance coverage is primary on Federal Employee members, primary insurance information must be filed on the claim.</p>

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201	<p>BC INSURED IDENTIFICATION NUMBER must be in one of the following formats:</p> <p>Blue Cross & Blue Shield contracts: Include all prefixes.</p> <p>State of Mississippi contracts: Nine (9) digits followed by alpha character.</p> <p>Federal Employee contracts: "R" followed by 8 digits.</p> <p>MC INSURED IDENTIFICATION NUMBER must be in the following format: NNNNNNNNNCSS Where N = Numeric Character C = Copay/Newborn Indicator S = Space</p>	<p>BC</p> <p>Verify subscriber ID number. Local Blue Cross & Blue Shield of MS ID numbers will usually start with a 'YA' prefix followed by 9 digits and a letter. Since most all Blue Cross & Blue Shield claims (from any state) should be sent to Blue Cross & Blue Shield of MS, be sure and enter ALL prefixes on ID numbers to ensure that the claim can be processed correctly.</p> <p>The letter 'O' should only be used in an alpha prefix; for example, it should never be used in a Federal Employee ID number. The '0' following the 'R' will always be a zero.</p> <p>Valid Copay Indicators: C = Child Under 18 Years of Age E = Emergency F = Family Planning Services K = Newborn N = Nursing Home Resident P = Pregnant Woman = Copay Should be Taken</p> <p>If Copay Indicator is 'K' Patient Birthdate and Patient Sex must be entered.</p>
202	<p>INSURED IDENTIFICATION must be valid</p>	<p>BC</p> <p>If the INSURED IDENTIFICATION number is the same as the card, search on-line using myAccessBlue for a valid number. If the ID is valid according to myAccessBlue, ensure the line of business was submitted correctly. For example, be sure a State ID number was submitted as a State of MS and not a regular Blue Cross.</p>
203	<p>BC</p> <p>For any given INSURED IDENTIFICATION NUMBER (Local Blue Shield), the patient information must meet <u>ALL</u> the following requirements:</p> <p>Exact match to the first three characters of the PATIENT FIRST NAME.</p> <p>Exact match to the PATIENT RELATIONSHIP.</p>	<p>BC</p> <p>The subscriber and all covered dependents, along with relationships and birth dates will be listed on the error report. Relationship "EE" is the subscriber.</p> <p>Beginning November 2008, Federal policies require an EXACT match on patient first name, last name, relationship code, sex and date of birth. Check eligibility information on myAccessBlue to ensure you have the patient information exactly as indicated.</p>

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	DATE OF BIRTH entered must be within one year of the patient date of birth on the enrollment file.	
204	<p>BC</p> <p>Not in coverage dates of policy</p>	<p>BC</p> <p>Listed under the last line of charges for the claim will be the policy number, members on that policy, their relation to the subscriber, their birth dates and their coverage dates. In the 'CANC DATE', '999999' indicates an active policy. If there is a newer policy, it will be listed also with the correct policy number - a 1, 2, 3, (etc.) on the end of the old policy number</p>
205	<p>GROUP NUMBER required</p>	<p>'CARD' payors (as listed on the NEIC Payor List) must have a claim office number. This is located on the ID card. It is the last four digits of the Payor Number.</p> <p>For Mass Mutual (payor 65935), the group number must be entered.</p> <p>For Cigna/Equicor (payor 62308 or 62309), group numbers 57800, 70600, 70602, 70605, 70607, 70609, 70610, 70611, 70612, 70613, and 70614 cannot be electronic.</p> <p>For Guardian (payor 64246): The group number must be 4 to 6 positions. The group number must be numeric. The group number may <u>not</u> = 000000, 111111, 099999, 999999 or 999990.</p> <p>For Allamerica Financial (payor 69140), Group number must be numeric.</p> <p>For New York Life (payor 66915), the group number must be: 4-6 characters Position 1 must = 0-9 or A-Z Positions 2-4 must = 0-9 Positions 5-6 must = 0-9 or spaces</p> <p>For Prudential (payor 68241) <u>neither</u> the Payor Name <u>nor</u> the Group Name may = "AARP", "A.A.R.P.", or "A A R P" - these claims cannot be electronic.</p>

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206	<p>BC</p> <p>The INSURED FIRST and LAST NAME must match the PATIENT FIRST and LAST NAME if patient relationship is SE (Self)</p> <p>BC and CM</p> <p>The INSURED FIRST NAME and LAST NAME must be present if PATIENT RELATIONSHIP is one of the following:</p> <p>01 = SPOUSE 19 = CHILD 18 = SELF</p>	<p>BC</p> <p>If the patient is also the subscriber, make sure the name of the insured appears exactly like the subscriber's.</p> <p>Be sure the name of the insured is reported if the patient is not the subscriber.</p>
207	<p>BC (AIB CONTRACTS ONLY), CM and MR</p> <p>An ACCIDENT DATE (DATE OF FIRST SYMPTOM) must be entered if an accident indicator of 'A' or 'O' is entered.</p> <p>An ACCIDENT DATE must be entered if a diagnosis in the range of 800-99499 is entered.</p>	<p>Additional Diagnosis requiring accident date:</p> <p>0059 6926 69270-69271 69273 69276-69279 800-96199 963-9931 9933-99499 V015 V155 V156 V664 V674 V713 V714 V716 V825</p> <p>AIB is Accidental Injury Benefits</p> <p>MR</p> <p>Date first seen is required for chiropractor, OT and PT claims.</p>
208	<p>BC, CM, and MR</p> <p>The FACILITY NAME, CITY and STATE <u>must</u> be present if the Hospitalization Admission Date is entered.</p> <p>BC and CM</p> <p>Hospitalization dates must be after date of first symptom.</p>	<p>If the patient was hospitalized, the hospital name, city and state must be entered.</p>

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ERROR NUMBER	DESCRIPTION	CORRECTIVE ACTION
209	<p>BC</p> <p>New Claim Administrator</p>	<p>BC</p> <p>Program no longer administered by BCBSMS. Please send the claim to the new program administrator.</p>
210	<p>BC, CM and MR</p> <p>FACILITY NAME must be present if PLACE OF TREATMENT is NOT equal to one of the following values:</p> <p>11 = PHYSICIAN'S OFFICE 12 = PATIENT'S HOME 99 = OTHER</p>	<p>Also, the zip code must be valid.</p>
211	<p>BC, CM, MR and MC</p> <p>At least one PROCEDURE CODE must have a diagnosis indicator equal to a value of '1' denoting PRIMARY DIAGNOSIS CODE.</p> <p>CM</p> <p>With the exception of ambulance claims.</p>	<p>BC, CM, MR and MC</p> <p>On line item charges, at least one procedure code must be pointing to the primary diagnosis.</p> <p>CM</p> <p>Ambulance claims must have a diagnosis indicator of '5'.</p>
212	<p>CM</p> <p>INSURED ID NUMBER <u>cannot</u> equal the GROUP POLICY/PLAN NUMBER.</p> <p>INSURED ID NUMBER <u>cannot</u> equal the PAYOR ID.</p>	
213	<p>BC, CM, MR and MC</p> <p>The sum of all CHARGES must equal the TOTAL CHARGE.</p>	
214	<p>BC</p> <p>If Source of Pay = 'C', then Payor Name must = 'MEDICARE'.</p>	

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215	BENEFIT PLAN NOT ACTIVE	BC Benefit Plan not active. Membership requirements as defined in the member's contract have not yet been met for this benefit plan.
216	BC OTHER INSURANCE ACCEPT ASSIGNMENT INDICATOR <u>must be</u> present if filing Blue Shield secondary to another insurance. MR If Medicare is secondary, the other insurance information is required – name of insured, relationship, date of birth, etc.	BC If other insurance amount is present, then other insurance name, insured name, insured id, accept assignment indicator, etc must also be present. MR Medicare secondary requires group name, group number, and records with all primary insurance information
218	BC and MC OTHER INSURANCE INDICATOR 'B' (Worker's Compensation) <u>must</u> have a work related value of Y Yes).	The claim shows as work related and should be filed with Workmen's Comp.
221	BC If the OTHER INSURANCE ALLOWED or PAID is entered for one line item it <u>must be</u> entered on all line items. CM PAYOR NAME must be entered	
222	CM GROUP NAME must be valid.	BC If the payment available indicator is 'Y', you must have either the denied reason <u>or</u> the allowed amount and paid amount.
223	CM SERVICING PROVIDER NETWORK ID required.	

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224	CM CLAIM OFFICE NUMBER must be entered.	If PAYOR NUMBER is 67814, 66915, or 87815, the CLAIM OFFICE NUMBER must be entered.
230	BC INVALID SUBMITTED BLUE CARD CLAIM	The charges were incurred or the claim received BEFORE or AFTER this prefix became valid. Contact the subscriber for accurate insurance information.
233	BC ORIGINAL DCN	When a corrected claim is indicated, the original document control number is required. This is the same as the claim number on the voucher.
234	BC CORRECTED CLAIM	A corrected claim must be received within 12 months of the original claim payment date.
235	BC CORRECTED CLAIM	Only one correction per original claim should be transmitted.
300	BC Multiple E&M codes for the same date of service are not allowed.	Resubmit the claim with only one E&M code for the date of service.

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301	<p>The FROM DATE OF SERVICE <u>must</u> meet the following conditions:</p> <p>BC and CM Must be <u>greater than or equal to</u> ACCIDENT/SYMPTOM DATE.</p> <p>BC, CM, MR and MC Must be <u>Less than or equal</u> THRU DATE OF SERVICE.</p> <p>BC, CM and MR Must be <u>Equal to</u> calendar year for the THRU DATE on the same line item.</p> <p>MR Must be FROM DATE OF SERVICE and THRU DATE OF SERVICE must be in the same fiscal year.</p> <p>MC If filing a claim over one year old, the original ICN is required.</p>	<p>The FROM DATE OF SERVICE and THRU DATE OF SERVICE must be valid for the procedure code.</p>
302	<p>BC and MR</p> <p>PLACE OF SERVICE must be valid for the PROCEDURE.</p>	<p>If services such as x-rays are performed at the hospital, the physician should be filing for the professional component and a '26' modifier is needed.</p>
303	<p>BC</p> <p>PATIENT'S AGE <u>must</u> be valid for the PROCEDURE.</p>	<p>Refer to the current AMA CPT Manual for specific age guidelines</p>
304	<p>BC</p> <p>PATIENT'S SEX <u>must</u> be valid for the PROCEDURE.</p>	
305	<p>BC</p>	

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ERROR NUMBER	DESCRIPTION	CORRECTIVE ACTION
	MODIFIER <u>must</u> be valid for PROCEDURE.	
306	<p>BC</p> <p>Verify that an UNUSUAL PROCEDURE CODE has an UNLISTED DESCRIPTION present.</p>	An unusual or 'unlisted' procedure code must have a description.
307	<p>BC, CM, MR and MC</p> <p>DIAGNOSIS must have one of the following values present:</p> <p>1 = PRIMARY DIAGNOSIS 2 = SECONDARY DIAGNOSIS 3 = TERTIARY DIAGNOSIS 4 = OTHER DIAGNOSIS</p> <p>CM</p> <p>5 = NO DIAGNOSIS CODE (AMBULANCE CLAIMS ONLY)</p>	<p>You must have a diagnosis indicator of 1, 2, 3, 4 or 5. (Commercial claims only)</p> <p>Can appear with errors 019, 020, 021 and 022.</p> <p>Check to make sure diagnosis code is valid according to the current ICD9 manual.</p>
308	<p>BC</p> <p>The primary surgical procedure must be on a line by itself with one unit. The primary surgical procedure is the procedure with the highest allowed amount.</p>	The allowed amount for the procedure can be found on myAccessBlue by clicking on Professional Allowance Inquiry from the home screen.
309	<p>BC</p> <p>The number of units allowed for this procedure code has been exceeded.</p>	This follows the Medically Unlikely Edits used by CMS. Refer to Medically Unlikely Edits National Correct Coding Initiatives Edits for a complete list of edits and unit limitations.
310	<p>BC</p> <p>The indicated code should not be on this claim with one of the other procedures. Code is included as an inclusive component of the primary procedure.</p>	This follows the Correct Coding Initiative (CCI) edits used by CMS. Refer to Overview National Correct Coding Initiatives Edits for a complete list of CCI edits.
311	<p>BC, CM and MC</p> <p>If PLACE OF TREATMENT is <u>equal to</u> one</p>	If PLACE OF TREATMENT is NOT equal to one

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ERROR NUMBER	DESCRIPTION	CORRECTIVE ACTION
	<p>of the following values:</p> <p>21 = INPATIENT HOSPITAL 32 = SKILLED NURSING FACILITY – EXTENDED CARE</p> <p>51 = PSYCHIATRIC NIGHT CARE FACILITY 55 = RESIDENTIAL SUBSTANCE ABUSE FACILITY</p> <p>DAY/UNITS <u>must be</u> present and <u>equal to</u> the <u>inclusive</u> difference between THRU DATE OF SERVICE and FROM DATE OF SERVICE.</p>	<p>of the values indicated, then the FROM DATE OF SERVICE must equal the THROUGH DATE OF SERVICE.</p>
<p>312</p>	<p>BC</p> <p>MODIFIER of AA, AD, QK, QY, QX or QK <u>must</u> have an associated ANESTHESIA MINUTES present.</p> <p>MODIFIER other <u>than</u> AA, AD, QK, QY, QX or QK <u>must not have</u> an associated TIME present.</p> <p>MR</p> <p>PROCEDURE CODES 00100-01999 requires a modifier and anesthesia time (anesthesia minutes).</p>	<p>This refers to anesthesia claims only.</p> <p>Anesthesia must be reported with time minutes.</p> <p>Modifiers AB and AC are only valid for dates of service prior to 12/31/2001.</p> <p>There ARE exceptions, refer to the Anesthesia Policy.</p>
<p>313</p>	<p>BC</p> <p>An E&M code is either within the pre-op or post-op period for its corresponding surgery code and the correct modifier was not included.</p>	<p>Resubmit claim with only the global code.</p>
<p>314</p>	<p>BC</p> <p>Other insurance allowed and other insurance paid cannot be greater than total charges per procedure.</p>	

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	If other insured allowed amount is present, then the other insurance indicator must be present.																
315	BC Code should be part of panel. All services for a lab panel must be filed with a panel code.	If lab CPT codes on the claim can be submitted as a panel, submit with just the panel code. Refer to the current AMA CPT manual and resubmit claim with the appropriate panel code.															
316	BC UNITS OF SERVICE are invalid for procedure code and FROM DATE/THRU DATE.	BC When filing Radiation Treatment Delivery Codes and Clinic Treatment Management Codes, the units should be filed as '01'. The minimum computed days (difference between the from and thru dates) should be as follows. <table data-bbox="933 835 1380 1024" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="text-align: center;"><u>CODE</u></th> <th style="text-align: center;"><u>MINIMUM DAYS</u></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">77419-77430</td> <td style="text-align: center;">03</td> </tr> <tr> <td style="text-align: center;">77431</td> <td style="text-align: center;">01</td> </tr> <tr> <td style="text-align: center;">90918-90921</td> <td style="text-align: center;">28</td> </tr> <tr> <td style="text-align: center;">G0308-G0324</td> <td style="text-align: center;">28</td> </tr> </tbody> </table> <p>DME code E0118 cannot be rented by the day. Modify claim to include no more than 1 unit for each 31 day period.</p> <p>NOTE When filing 'event recording' procedure codes, statement from and thru dates must be at least a 30 day period. Enter '1' for the units. This should be followed for the following procedures:</p> <table data-bbox="982 1386 1063 1543" style="margin-left: auto; margin-right: auto;"> <tbody> <tr><td style="text-align: center;">93014</td></tr> <tr><td style="text-align: center;">93268</td></tr> <tr><td style="text-align: center;">93270</td></tr> <tr><td style="text-align: center;">93271</td></tr> <tr><td style="text-align: center;">93272</td></tr> </tbody> </table>	<u>CODE</u>	<u>MINIMUM DAYS</u>	77419-77430	03	77431	01	90918-90921	28	G0308-G0324	28	93014	93268	93270	93271	93272
<u>CODE</u>	<u>MINIMUM DAYS</u>																
77419-77430	03																
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90918-90921	28																
G0308-G0324	28																
93014																	
93268																	
93270																	
93271																	
93272																	
317	BC Add on code not submitted with base code.	The base code was not present on the claim. Add on codes are only valid when used in conjunction with their applicable base code. A corrected claim is required if the base code has already been submitted on a separate claim.															

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318	<p>BC</p> <p>Use of modifier requires documentation.</p>	<p>Claim will be accepted but not processed for benefits until medical documentation is received to support use of the modifier. You must submit the medical records using the Provider Correspondence form located on www.myaccessblue.com.</p>
319	<p>Disease Specific Pharmacy</p>	<p>If the procedure code falls in the DSP list (see list below), and the DOS from date is on or after 1/1/09, then the NDC must be present and valid, and the metric qty must be present</p> <p>'90281' '90283' '90284' '90378' 'C9003' 'C9399' 'J0129' 'J0135' 'J0180' 'J0205' 'J0215' 'J0256' 'J0364' 'J0585' 'J0587' 'J1325' 'J1438' 'J1458' 'J1459' 'J1460' 'J1470' 'J1480' 'J1490' 'J1500' 'J1510' 'J1520' 'J1530' 'J1540' 'J1550' 'J1560' 'J1561' 'J1562' 'J1566' 'J1568' 'J1569' 'J1572' 'J1595' 'J1743' 'J1745' 'J1785' 'J1825' 'J1830' 'J1931' 'J2170' 'J2323' 'J2357' 'J2503' 'J2504' 'J2778' 'J2941' 'J3285' 'J3490' 'J3590' 'J7186' 'J7187' 'J7189' 'J7190' 'J7192' 'J7193' 'J7194' 'J7195' 'J7198' 'J7311' 'J8499' 'J9212' 'J9213' 'J9214' 'J9216' 'J9310' 'Q3025' 'Q3026' 'Q4080' 'Q4096' 'Q4097' 'S0145' 'S0146' 'S0162'.</p>
320	<p>BC</p> <p>Invalid Modifier for Provider Type</p>	<p>Modifier is not valid for use by this provider type.</p>
321	<p>BC</p> <p>Invalid NDC code submitted.</p>	<p>Verify the NDC code and resubmit. The NDC code is in the format of XXXXX-XXXX-XX. Do not submit the dashes.</p>
322	<p>BC</p> <p>Diagnosis and procedure code are not compatible</p>	<p>Please resubmit the claim with an appropriate wellness diagnosis code for the wellness visit.</p>
323	<p>BC</p>	

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	Diagnosis is not valid for wellness services	Please resubmit the claim with an appropriate wellness diagnosis code.
324	BC Lab/immunization code related to the venipuncture and/or immunization administration code is not present	Please resubmit the claim with the associated laboratory or immunization code. If there is no separate charge applicable, please indicate the related CPT/HCPCS code for the venipuncture or immunization administration charge(s) in the description field.

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EXHIBIT A

STANDARD POST OFFICE STATE ABBREVIATIONS

ALABAMA	AL	UTAH	UT
ALASKA	AK	VERMONT	VT
ARIZONA	AZ	VIRGINIA	VA
ARKANSAS	AR	WASHINGTON	WA
CALIFORNIA	CA	WEST VIRGINIA	WV
COLORADO	CO	WISCONSIN	WI
CONNECTICUT	CT	WYOMING	WY
DELAWARE	DE		
DISTRICT OF COLUMBIA	DC		
FLORIDA	FL		
GEORGIA	GA		
HAWAII	HI		
IDAHO	ID		
ILLINOIS	IL		
INDIANA	IN		
IOWA	IA		
KANSAS	KS		
KENTUCKY	KY		
LOUISIANA	LA		
MAINE	ME		
MARYLAND	MD		
MASSACHUSETTS	MA		
MICHIGAN	MI		
MINNESOTA	MN		
MISSISSIPPI	MS		
MISSOURI	MO		
NEBRASKA	NE		
NEVADA	NV		
NEW HAMPSHIRE	NH		
NEW JERSEY	NJ		
NEW MEXICO	NM		
NEW YORK	NY		
NORTH CAROLINA	NC		
NORTH DAKOTA	ND		
OHIO	OH		
OKLAHOMA	OK		
OREGON	OR		
PENNSYLVANIA	PA		
RHODE ISLAND	RI		
SOUTH CAROLINA	SC		
SOUTH DAKOTA	SD		
TENNESSEE	TN		
TEXAS	TX		

AMERICAN TERRITORIES

AMERICAN SAMOA	AS
CANAL ZONE	CZ
GUAM	GU
PUERTO RICO	PR
TRUST TERRITORIES	TT
VIRGIN ISLANDS	VI

CANADIAN PROVINCES

ALBERTA	AB
BRITISH COLUMBIA	BC
LABRADOR	LB
MANITOBA	MB
NEW BRUNSWICK	NB
NEWFOUNDLAND	NF
NORTHWEST TERRITORY	NT
NOVA SCOTIA	NS
ONTARIO	ON
PRINCE EDWARD ISLAND	PE
QUEBEC	QB
SASKATCHEWAN	SK
YUKON	YK

OTHER THAN THE U.S. OR CANADA
USE CODE - XX.

EXHIBIT B

VALID PLACE OF TREATMENT VALUES

- 11 OFFICE
- 12 HOME
- 21 INPATIENT HOSPITAL
- 22 OUTPATIENT HOSPITAL
- 23 EMERGENCY ROOM - HOSPITAL
- 24 AMBULATORY SURGICAL CENTER
- 25 BIRTHING CENTER
- 26 MILITARY TREATMENT FACILITY
- 31 SKILLED NURSING FACILITY
- 32 NURSING FACILITY
- 33 CUSTODIAL CARE FACILITY
- 34 HOSPICE
- 41 AMBULANCE - LAND
- 42 AMBULANCE - AIR OR WATER
- 50 FEDERALY QUALIFIED HEALTH CENTER
- 51 INPATIENT PSYCHIATRIC FACILITY
- 52 PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
- 53 COMMUNITY MENTAL HEALTH CENTER
- 54 INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
- 55 RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
- 56 PSYCHIATRIC RESIDENTIAL TREATMENT CENTER
- 61 COMPREHENSIVE INPATIENT REHABILITATION FACILITY
- 62 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
- 65 END STAGE RENAL DISEASE TREATMENT FACILITY
- 71 STATE OR LOCAL PUBLIC HEALTH CLINIC
- 72 RURAL HEALTH CLINIC
- 81 INDEPENDENT LABORATORY
- 99 OTHER UNLISTED FACILITY