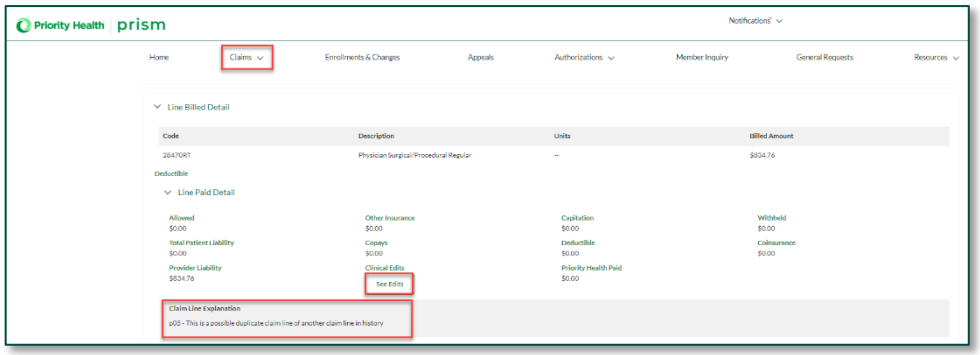
Understanding claim denial explanation codes

In prism, you can see exactly how your claim processed. If an edit applied to your claim, you'll see an explanation code with a brief description of the denial. Because each explanation code may apply to multiple edits, we provide additional information / rationale through:

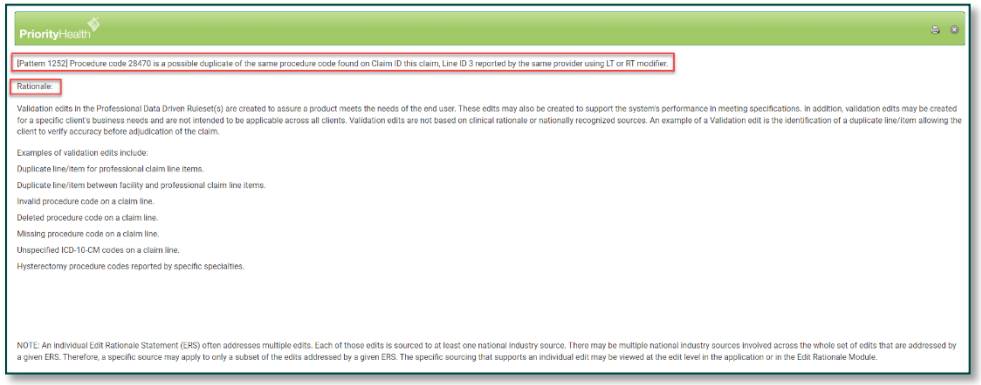
1 prism's See Edits button

For many explanation codes, we're able to share additional information right in prism. If this is the case, you'll see a **See Edits button** above the explanation code. Click it for further explanation.



2 This resource document

If you see an explanation code on your claim but don't see the See Edits button in prism, reference this document. Be sure to bookmark it as we'll continue to update it with additional explanation codes.



COMMON **EXPLANATION CODES**

Below is a list of common explanation codes that you may see on your claim with detailed edit reasons for why that code may be applied. Click a code or scroll down for explanations.

Note: We'll continue to add explanation codes to this resource. Please bookmark / save the URL to always have the most updated version.

E4E or E2K

prism description	Deny duplicate service
Detailed edit reasons	• Based on CPT/HCPCS code description • Once per lifetime service reported more than once per lifetime • Co-surgery modifiers reported more than once regardless of provider • DME/PO item reported within 5 years of a rental or purchase of same item regardless of provider • CPAP items billed more than once in 3-month period regardless of provider • Transitional Care Management (TCM) code reported within 29 days regardless of provider • Annual Wellness Visit reported more than once in 11 months regardless of provider • Rental item reported more than once per month regardless of provider • Any lipid test reported more than 6 times per year regardless of provider • Any Portable/Stationary oxygen delivery system reported more than once per month regardless of provider • This service is not separately payable when performed with another ultrasound for the same anatomical sites. This is considered redundant when performed during the same session to evaluate related conditions.

E3X

prism description	Duplicate line by provider
Detailed edit reasons	Duplicate claim - claim or claim line that has been previously processed for payment

E03

prism description	Diagnosis reported incorrectly
Detailed edit reasons	The diagnosis codes on your claim have an excludes1 relationship. An excludes1 designation for diagnosis codes occurs when the two conditions can't occur together. This means the code flagged for this designation should not be coded at the same time as another diagnosis on the claim.

E3S

prism description	Denied for incorrect CPT / HCPCS
Detailed edit reasons	• Procedure is denied based on CPT/HCPCS definition • Procedure is denied based NCCI Policies and Guidelines • Global only codes with a single professional and technical component or TC/26 reported when code does not have professional/technical component • Ambulance claim reported without origin/destination modifier • Ambulance transport billed without mileage codes on same date of service • Portable x-ray transportation service reported without one of the x-ray transportation modifiers • Initial observation care code reported when an initial observation code has been billed for the previous day regardless of provider • Hospital discharge services reported when discharge has been reported the previous day • Outpatient/Office consult service in office setting reported when another E/M service has been reported in previous year • Second initial hospital care service reported when inpatient consult, subsequent hospital, or another initial hospital service has been billed in previous week, without a discharge service also reported in previous week • Hospital discharge services reported when hospital discharge services have been reported on subsequent date of service regardless of provider • Global delivery code reported when antepartum care only code reported in last 8 months, or subsequent billings of antepartum codes, regardless of provider • Subsequent delivery codes reported when delivery code billed within previous 6 months regardless of provider • P&O and DME items reported without required modifiers • Vaccine admin code reported without vaccine/toxoid code on same date of service • Misuse of modifier SH • Reporting services for certain anatomic sites that have previously been removed, regardless of provider • New patient code used when face-to-face service has been performed within 3 years, regardless of provider • Contrast reported without imaging service • Initial pediatric/neonatal critical care reported when member has had inpatient critical care services the previous day, regardless of provider • Misuse of modifier JW on drug codes • Major procedure reported when same procedure has been reported in previous 90 days, regardless of provider

	• Surgical pathology gross & microscopic exam reported with encounter for sterilization diagnosis only

E8C or E1P

prism description	Maximum frequency exceeded
Detailed edit reasons	• The frequency for this service or item has been exceeded • Units for CPT/HCPCS have been exceeded, allowed amount has been adjusted to reflect • Additional units may have been billed by another provider • The limit is based on total units regardless of who is providing these supplies or services • This frequency may be based on code description, an NCD/LCD, or MUE defined by CMS • Assistant at surgery modifiers not used appropriately to indicate procedure performed by assist at surgery • Annual assigned allowable unit(s) for procedure exceeded for member • More than one unit of service for a code with an anatomical modifier (E1-E4, FA-F9, TA-T9) • Observation services billed more than one unit per day in any combination, regardless of provider • J1745, Q5103, Q5104, Q5109, or Q5121 over 544 combined units in 26 weeks diagnosis on the claim is regional enteritis, regardless of provider • Over 60 units J2357 reported per month by any provider, diagnosis on the claim is chronic idiopathic urticaria, immune checkpoint inhibitor-related toxicity, or systemic mastocytosis • Allergy testing performed more than 30 times in a year, regardless of provider • Indwelling catheters reported more than 3 times in any combination in 3 months • CMP device reported more than once per day, or within 3 previous 3 weeks of original arthroplasty, regardless of provider • Intermitting urinary catheters reported 600 combined units in 3 months • Over 380 combined units of J2315 in 4 weeks, regardless of provider

E2Q

prism description	Maximum frequency exceeded
Detailed edit reasons	• Frequency limitation has been exceeded based on clinical guidelines for this CPT/HCPCS • Screening colonoscopy reported more than once every 2 years, regardless of provider • Screening mammography billed more than once for member ages 35-39, regardless of provider • Screening mammography billed more than once per year for member age 39+, regardless of provider • Screening pelvic exam billed more than once in 2-year period, regardless of provider (except when high risk dx reported) • Gastrostomy/jejunostomy tube reported more than once every 3 months, regardless of provider • PET services reported with PS modifier more than 3 times for same diagnosis • IMRT reported more than once in 8 weeks • Oncology colorectal screening reported more than once every 3 years, regardless of provider • Annual depression screening reported more than once per year, regardless of provider • Physician recertification for home health reported more than once every 2 months

E1B

prism description	Unbundled procedure
Detailed edit reasons	• National Correct Coding Initiative unbundling relationships (NCCI) • NCCI manual policy • CPT coding guidelines for “separate procedure” • Based on CPT and HCPCS procedure code definition. • Auditory screening reported at the time of preventive or annual wellness visit • E/M service reported same day as electromyography, nerve conduction tests or reflex tests • Surgical dressings are considered inclusive of professional services in the office • Observation discharge reported when initial hospital care was reported the previous day, regardless of provider • Oxygen accessories and supplies billed the same day or during the same month as a monthly oxygen rental billing, regardless of provider • Lab tests: Urinalysis, Creatinine, pH; body fluid, Spectrophotometry billed with a toxicology procedure • E/M services billed the same date of service as cardiovascular services (93260-93261, 93282-93284, 93287, 93289, 93292) or cardiac device monitoring services, cardiac device evaluation services, or noninvasive physiologic studies • Intensity modulated radiation therapy (IMRT) billed two weeks prior to an IMRT plan (77301) and the primary diagnosis is the same as any diagnosis on the IMRT planning claim line, regardless of provider

E3G

prism description	Required modifier not reported
Detailed edit reasons	• CPT/HCPCS is not consistent with the modifier used • Required modifier is not reported • LCD modifier requirements not followed • Home glucose monitoring supplies reported without required modifier • DME/P&O items reported without appropriate anatomic modifiers • DME items reported without KX modifier as appropriate • Surgical dressings reported without A1-A9 or GY billed by a DME provider • Modifier 26 and TC reported on the same claim line • Physical medicine and rehabilitation services without therapy modifier

E4S

prism description	Service denied because the related / qualifying service was not paid
Detailed edit reasons	• Ambulance mileage, supplies or other services reported without an ambulance transport code reported for the same date of service • Reporting J2507 with a diagnosis code of chronic gout and a uric acid lab has not been reported on the same day or within the last two weeks. • J0178, J2778 or Q5124 reported without intravitreal injection of a pharmacologic agent • Anesthesia and moderate sedation services reported with pain management services without a surgical code, regardless of provide • The set up of portable x-rays when the transportation of the portable x-ray equipment has not been reported on the same day, regardless of provider. • Transportation of portable x-ray equipment when the accompanying radiological service has not been billed for same date of service regardless of provider • Reporting J0775 with Peyronie's disease and injection code 54200 has not been billed for the same date of service by any provider. • Billing nerve conduction study codes (95907-95913) with needle electromyography (95885, 95886) or continuous intraoperative neurophysiology monitoring (95940, 95941, G0453) and radiculopathy is the only diagnosis code on the claim. • Billing multiple units of E0935 when the number of units exceed one unit per day. • Using modifier JW on a drug and the same drug was not billed on the same day.

E2N

prism description	The principal diagnosis has been inappropriately coded based on ICD-10 guidelines
Detailed edit reasons	• Reporting an external causes ICD-10 code as the primary/principal diagnosis code. • Reporting antineoplastic ICD-10 codes without a secondary diagnosis code for the current disease. • Reporting a manifestation ICD-10 code and it's the only ICD-10 code on the claim. • Reporting a secondary ICD-10 code as the primary/principal diagnosis code. • Reporting a secondary ICD-10 code and the primary/principal diagnosis code is not valid. • Reporting the initial annual visit (G0438) more than once in the patient's lifetime. • Reporting a sequela ICD-10 code as a primary.

E2C

prism description	Procedure not typical for age
Detailed edit reasons	• CPT/HCPCS codes that are inconsistent with the patient's age based on the code definition • Diagnosis codes that are inconsistent with the patient's age based on the code definition • Mammograms for patients who are younger than 35. • Digital rectal exams for patients younger than 50. • Colorectal cancer screening (blood-based tests) for patients younger than 50 and older than 85. • CT of the thorax and the counseling visit when done for patients younger than 50 and older than 80.