Claims Edit System (CES) – Significant Professional Edits

Code ID	Explanation Code Description	Edit Detail Reason	Code ID	Explanation Code Description	Edit Detail Reason
J02	Care management services not allowed	Behavioral health care management services not allowed in the same calendar month as psychiatric collaborative care management.	J16	CPT code not covered - submit HCPCS code	The quantitative drug CPT code billed is non-reimbursable. Submit services with the appropriate HCPCS code.
J03	Anesthesia modifiers	Anesthesia procedure submitted without a modifier.	J17	DOS to units discrepancy	The number of units doesn't match the date span between the beginning and ending dates of service.
J04	Anesthesia secondary procedure	More than one anesthesia procedure code billed on the same date of service.	J19	Modifier 62 not present on procedure code	This service was previously reported with modifier 62 by a different provider for this date of service.
J05	Originating site fee not allowed	Telehealth originating site fee is not allowed when billed by the distant site provider.	J20	Global follow-up by provider	An Evaluation & Management (E&M) code is within the global period with a same diagnosis category by the same provider.
J06	Unbundled proc-robotic surgery	The service is considered bundled or included as part of the primary surgical procedure and is not separately reimbursable.	J22	Post-op surgery by provider	A surgical code was submitted within the global period with a diagnosis from the same category by the same provider.
J08	Facility-specific HCPCS Code	This edit identifies when any of the HCPCS procedure codes billed is a facility service and should not be reported on a professional claim.	J25	Inappropriate billing of modifier 25	Modifier 25 is inappropriately submitted on an Evaluation and Management service with no **minor** procedure provided.
J09	Component of this procedure previously allowed	The global procedure of a component of the procedure was previously allowed.	J26	Inappropriate billing of modifier 57	Modifier 57 is inappropriately submitted on an Evaluation and Management service with no **major** procedure provided.
J10	Procedure not typical for age	The procedure code is not typical for the member's age.	J27	Diagnosis not typical for age	One of the diagnosis codes is not typical for the patient's age.
J11	Deleted procedure code	The procedure code was deleted.	J29	Invalid diagnosis code	The diagnosis code on this line is invalid.
J12	Invalid procedure code	The procedure code is missing or invalid.	J30	ICD9 DX submitted after ICD-10 effective date	ICD-9 code has been submitted for a claim with a date of service of October 1, 2015, or after, which requires an ICD-10 code.

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J32	Non-specific diagnosis code	The diagnosis code requires a fourth and/or fifth digit to provide appropriate specificity.	J44	Service not covered after 14th day of birth	These services are not covered by this provider after the 14th day of birth.
J33	Inappropriate modifier combination	The claim line contains an inappropriate modifier combination.	J45	Typical daily freq exceeded	The daily frequency for the procedure has been exceeded.
J34	Invalid modifier code	A modifier on the line is invalid.	J46	SVS included in other mat care provider	This service is considered a component of maternity care services and should not be submitted separately.
J37	Services by this provider not covered	The provider is not eligible as defined under the terms of your plan.	J47	SVS included in home birth supply kit	Reimbursement for the service submitted is included in the home birth supply kit or in the facility reimbursement.
J38	CPT code not covered - submit HCPCS code	The qualitative drug CPT code billed is non-reimbursable. Submit services with the appropriate HCPCS Code.	J48	SVS included in facility fee allowance	This service is included in the facility fee reimbursement and should not be submitted separately.
J39	KX modifier needed for CPAP compliance	This claim line identifies PAP rental services billed with an apnea diagnosis and denies if the provider does not indicate that the services are compliant with the medical policy.	J50	DME submitted without a modifier	A DME/HME code was submitted with a provider indicating a purchase or rental.
J40	Routine maternity E&M Service max exceeded	The maximum frequency for routine maternity E&M services has been exceeded.	J51	DME submitted with units >1 no MOD KR	The Home Medical Equipment code modifier was inconsistent with the units submitted.
J41	Compliant rental period not documented	The required 3 months of compliant rental for the CPAP machine has not been documented.	J52	Modifier not typical for procedure	A modifier on the line is not typical for the procedure code.
J42	Performing lab must bill this service	Laboratory services must be submitted directly to Premera by the provider who performed the laboratory test.	J53	Inappropriate use of modifier 91	A repeat lab modifier is inappropriate since another lab service without a repeat lab is not found.
J43	Services outside the scope of providers LLC	This claim line denies when a service is billed outside the scope of a licensed midwife's license.	J54	Repeat lab billed without repeat modifier	A repeat laboratory procedure was submitted without a repeat laboratory modifier performed on the same date of service.

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J55	Modifier 26 required	A diagnostic/radiology procedure submitted requires a professional component modifier.	J68	Repeat radiology requires repeat modifier	This claim line disallowed because records indicate this is a repeat radiology service that has been billed without a repeat modifier.
J57	PT/OT policy limitation exceeded	The daily policy limitation for physical or occupational therapy was exceeded.	J69	Prolonged services not covered for labor management	Labor management is considered a component of maternity care and is not reimbursable.
J58	Maximum frequency exceeded drug assay	The maximum frequency for drug assay services was exceeded.	J70	Rebundle to appropriate procedure	The procedure code is disallowed as part of a rebundle relationship.
J60	Not a primary diagnosis	This edit identifies when a diagnosis billed in a non-primary position is considered a primary diagnosis code and may only be used as first-listed diagnosis position.	J71	Multiple assistant surgery	Only one surgical assistant is allowed per procedure code.
J61	New pt code billed for est pt	A new patient E&M service was billed for an established patient.	J72	Typically, no surgical assist	The procedure code does not typically allow an assistant surgeon modifier.
J62	Inappropriate modifier to diagnosis	A modifier on the claim line is inappropriate with a diagnosis billed.	J73	Px billing by multi providers w/o modifier 62	This claim line is being disallowed because this procedure was billed by another provider on this date of service without a co-surgeon modifier.
J63	Invalid prof component mod	The professional component modifier 26 is not appropriate with a 100% technical procedure.	J75	96376 not payable to a professional provider	This edit identifies when the sequential intravenous push code 96376 is reported by a professional provider. This service may only be reported by a facility and is not payable to a professional provider.
J64	POS not typical for procedure	The place of service is not typical for the procedure code.	J76	Unbundled proc - exclusive	The procedure code is unbundled and is considered exclusive.
J65	Primary diagnosis only	This edit identifies when a diagnosis billed in the first-listed position is **not** considered a primary diagnosis and may only be submitted in a non-primary position.	J77	UNB proc - UNB or incidental	The procedure code is unbundled and is considered unbundled or incidental.
J66	Surgical pre-op E&M procedure	A pre-operative E&M spell this out was billed the day before or the same day as a surgical procedure.	J81	Units exceed recommended dosage	Submitted units exceed the manufacturer's recommended dosage.

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J82	Service not eligible for reimbursement	Separate reimbursement for this service not provided.	J96	Same or similar services previously received	Maternity services previously submitted by same or different provider.
J84	Medicare status B indicator	The procedure code is identified as a Medicare Status B Code.	J97	OB chem urinalysis included in OB care	Routine chemical urinalysis not allowed separately - these services are included in routine maternity care.
J85	Add-on Px submitted without the primary Px	Add-On Px code submitted without appropriate primary Px code not allowed.	J98	Routine OB services - rebill OB care code	Evaluation and management services for routine maternity care should be billed using maternity care codes.
J86	Deny add-on procedure code	The primary procedure related to this add-on code previously submitted was denied. The add-on code is not allowed.	J99	Consult code not covered - submit w/ E&M code	The consult code billed is non-reimbursable. Submit services with the appropriate evaluation and management code.
J87	Non-covered service	Non-covered procedure disallowed.	JA0	Maximum frequency exceeded	The maximum frequency for this procedure has been exceeded.
J88	Maximum frequency exceeded	The maximum frequency for this procedure has been exceeded.	JA1	Mod not valid with prov credentials	Assistant surgeon modifier not valid with credentials of provider.
J89	E-visit frequency limit exceeded	Plan allows only 1 e-visit per 7-day period for the same condition.	JA2	Post-op surgery by provider	A surgical code was submitted within the global period of a previous procedure by the same provider.
J90	State-supplied vaccine not reimbursable	Reimbursement for state-supplied vaccine is not allowed.	JA3	Services included in facility fee allowance	This service is included in the facility fee reimbursement and should not be submitted separately.
J91	UIN proc incidental	The procedure code is considered incidental.	JA4	Services included in home birth supply kit	Reimbursement for the service submitted is included in the home birth supply kit or in the facility reimbursement.
J92	MOD not allowed if PHYS is same as surg	Modifier allowed only if surgery and pre/post-op care delivered by unrelated clinic physicians.	JA5	Surgical pre-op E&M procedure	The pre-operative E&M spell out was billed the day before or the same day as a surgical procedure.
J93	Provider's license has expired	Benefit not covered due to expired provider's license.	JA6	Global follow-up by provider	An evaluation code was submitted within the global period of a previous procedure by the same provider.

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JA7	DME submitted with units >1 no MOD KR	The Home Medical Equipment code modifier was inconsistent with the units submitted.	JA9	New patient code billed for established patient	A new patient visit was billed for an established patient.
JA8	Name of delivering provider required	Unlisted maternity care submitted for labor management requires the name of the delivering provider.	JB9	Chronic Care Management (CCM) included in other Billed Services	This edit identifies when Complex Care Management services (99487-99489) and Chronic Care Management services (99490-99491, 99439) are included in End Stage Renal services (90951-90970) or Physician Supervision services (G0181-G0182) when provided during the same calendar month.

Use the Claims Editor (What If) tool to enter a combination of codes and see how our claims editing software edits the codes. Find it under Tools at premera.com/wa/provider/.

If you have questions about this list, contact your Premera Provider Network Representative.