Family Care Claim Explanation Codes

If the claim was denied in full, submit the claim again as a new claim to WPS. If the claim was partially paid or denied, please use the Corrected Claim Form.

Denial Code	Description
105, ABF, ABG, AHZ	Primary carrier's Explanation of Benefits is required.
349, AAZ, AIA, W39	Medicare Explanation of Benefits is required.
AAA	Resubmit claim to Medicare with the information requested. When Medicare has determined benefits, send the Medicare Explanation of Benefits to us for processing.
AAB	Medicare assignment was accepted and the provider has agreed to reduce the charge by this amount. No patient responsibility.
AAM, AHO, CDD	This claim is a duplicate of a previously submitted claim.
AAV, AAW	The Explanation of Benefits received from the primary carrier does not reflect the original paid/denied charges. Please submit the original explanation.
ABY, AIH	The charges are not covered because they were billed in error by the provider of service.
ACZ	Claim processed per coordination of benefits with the patient's primary plan coverage. This may result in a reduction of payment.
AEF	Family Care coordination of benefits calculation method.
AHP	This service line is a duplicate of a previously submitted claim.
AIF, ANM, TF0	This claim was submitted after the claim filing limit.
AJN, XDX	The diagnosis code(s) entered is invalid for the date(s) of service billed on the claim.
AJO, K01, S10, S11, S12, S13, S14, S1A, S1C, S20, S21, S22, S23, S9, W01	The patient's coverage was not in effect on the date the services were provided.
AMQ, AMS	Primary carrier has requested additional information. When primary has determined benefits, resubmit claim and Explanation of Benefits for processing.
AMR, AMT	Claim was not submitted to primary in a timely manner. When primary has overturned its decision, resubmit claim and Explanation of Benefits for processing.
AMX, FAA	This service or supply was submitted without an authorization number. Please submit with the Family Care Managed Care Organization authorization number.
ANF	Payment based on contracted rate or Medicaid fee schedule.
FAC	Extra mileage service is not reimbursable without the base transportation code billed on the same claim with the same date of service.

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Denial Code	Description
FA1	EVV claims with a date range are not accepted. Resubmit claim as single line items per date of service.
FA2	No EVV visit key found; EVV claims without a matching visit key are not payable.
FA3	The number of units billed for this date of service exceed the number of remaining EVV visit key units.
FA4	There are no remaining EVV visit key units for this date of service.
FAD	The authorization number submitted is invalid for the service or supply billed.
FAE, Y68	The authorized number of units or amount for this service have been exceeded.
FAF	The service or supply submitted does not match the authorization. Resubmit with the correct service code.
FAH	The required NPI number is missing from the claim.
FAI	The provider of service was not authorized to provide this service.
FAJ	The NPI number submitted was not valid.
FAK	The date of service is either before or after the date range authorized.
FAL	Date of service for extra mileage code must be the exact same date of service as the base transportation code.
FAM	The customer number submitted on the claim does not match the customer number on the authorization referenced.
FAV	Future EVV claims billed with a date range will not be accepted. Services should be billed as single lines.
FAW	No EVV visit key found. An EVV visit key is required to pay services. Future EVV claims without a macthing visit key will not be accepted.
FAX	In the future this claim will not be paid. The units billed for this date of service exceed the number of remaining EVV visit key units.
FAZ	In the future, this claim will not be paid. There are no remaining EVV visit key units for this date of service.
NON	Provider is not in the Managed Care Organization/County Waiver Agency network.
WG0	The type of bill submitted is invalid for the date of service on the claim.
WG3	Personal care and home health services must be billed on an Institutional claim with a valid revenue code and authorized CPT/HCPCS code.
WGM	The place of service submitted is invalid for the date of service on the claim.
XPC, y28, z12	The procedure code(s) entered is invalid for the date(s) of service billed on the claim.

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 33233-100-2011