| Denial Codes Found on Explanations of Payment/Remittance Advice (EOPs/RA) | | |
|---|---|---|
| **Denial Code** | **Description** | **Denial Language** |
| **1** | Services after auth end | The services were provided after the authorization was effective and are not covered benefits under this plan. |
| **2** | Services prior to auth start | The services were provided before the authorization was effective and are not covered benefits under this plan. |
| **3** | No auth on file | There is no authorization on file for these services. |
| **4** | Max Days | This claim exceeds the maximum allowed days per benefit period |
| **5** | Not member | Denied: No coverage effective at time of service. |
| **6** | Benefit Day Limit Exceeded. | Benefit Day Limit Exceeded. |
| **7** | No benefit | The patient does not have benefits for this service under this Plan. |
| **8** | Not covered | The service provided is not a covered benefit under this plan. |
| **9** | Before eff date | The date you received medical services on the above claim was prior to your effective date of eligibility with this Plan. Please submit your claim to the appropriate Plan. |
| **10** | Prior auth required | Utilization Management has denied prior authorization for this service. |
| **11** | Not a benefit | Not a benefit |
| **12** | Exceeds annual amount | This claim exceeds the annual amount allowed for this benefit. |
| **13** | Lifetime max | This claim exceeds the lifetime maximum allowed for this benefit. |
| **14** | Visit limit | This claim exceeds the visit limit allowed for this benefit. |
| **15** | Dollar limit | This claim exceeds the dollar limit allowed for this benefit. |
| **16** | Exceeds auth | This services exceeds the number of services authorized. |
| **17** | Auth for different provider | The authorization on file was issued to a different provider. |
| **18** | Experimental | Procedure has been determined as being experimental in nature. |
| **19** | Mental Health | This claim is the responsibility of Bravo Health's Delegated Mental Health Vendor. This claim has been forwarded on your behalf. |
| **20** | Not covered | This service is not a covered benefit for this plan |
| **21** | Capitated | This is a capitated service. |
| **22** | Hospice | Hospice Member - Submit to Original Medicare |
| **23** | Capitated | This is a capitated service. |
| **24** | CompCare | Submit all Inpatient Mental Health to Comp Care |
| **26** | Vision | This claim is the responsibility of Bravo Health's Delegated Vision Vendor. This claim has been forwarded on your behalf. |
| **27** | Health and Wellness | This claim is the responsibility of Bravo Health's Delegated Health & Wellness Vendor. This claim has been forwarded on your behalf. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **28** | Dental | This claim is the responsibility of Bravo Health's Delegated Dental Vendor. This claim has been forwarded on your behalf. |
| **29** | Adjusted claim | This is an adjusted claim. |
| **30** | Auth match | The services billed do not match the services that were authorized on file. |
| **31** | Not covered Medicare | This service is not covered by Medicare. |
| **32** | Not covered benefit | This service is not a covered benefit for this plan however the patient is not liable for payment as the Non-coverage provided to the patient did not comply with the program requirements |
| **33** | POS | Please resubmit this claim with the correct place of service. |
| **35** | Per Diem | Services included in Per Diem |
| **36** | Facility | Services included in facility fee |
| **37** | RUGS | Services included in RUGS rate |
| **38** | Visit | Services included in visit rate |
| **39** | Invalid revenue code | Claim has been submitted with an invalid revenue code. Please resubmit a corrected claim. |
| **40** | Invalid modifier | The modifier submitted on this claim is invalid for the date of service. Please resubmit claim with a valid modifier. |
| **41** | Invalid procedure code | The procedure code billed is not valid. Please resubmit this claim with a valid code. |
| **42** | Invalid ICD9 code | Please resubmit this claim with a valid ICD9 diagnosis code. |
| **43** | Par filing deadline exceeded | All claims for participating providers must be submitted within 180 days of the date of service. This claim was submitted after the filing deadline. |
| **44** | No detail | Please resubmit this claim with a detailed bill showing the charges and specific services for each date of service. Itemized bills can be faxed to 1(877)-788-2764 |
| **45** | No EOB | Please resubmit with EOB in order to complete processing of the claim. |
| **46** | No occurrence code | Please resubmit with corrected Occurrence Code on claim |
| **47** | Correct occurrence span | Please resubmit with corrected Occurrence Code Span on claim. |
| **48** | Correct condition code | Please resubmit with corrected Condition Code on claim. |
| **49** | Duplicate Claim Line (Same Member/DOS/CPT(REV) | Duplicate Claim Line (Same Member/DOS/CPT(REV) |
| **50** | Duplicate Mem/DOS/Pay To/Rendering Phys/Charges | Duplicate Mem/DOS/Pay To/Rendering Phys/Charges |
| **51** | Invalid claim data found on IRF claim. | Invalid claim data found on IRF claim. |
| **52** | Benefit Requires Contracted (PAR) provider. | Benefit Requires Contracted (PAR) provider. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **53** | Benefit requires non-contracted (NONPAR) provider. | Benefit requires non-contracted (NONPAR) provider. |
| **54** | Service not within the scope of your contract. | Service provided is not included within the scope of your contract. |
| **55** | Incorrect value code | Please resubmit with corrected Value Code on claim |
| **56** | Incorrect admission date | Please resubmit with corrected Admission Date on claim |
| **57** | Discharge status required | Discharge status is required for inpatient and SNF claims. |
| **58** | Admission source required | Admission source required |
| **59** | Incorrect patient status | Please resubmit with corrected patient status for bill type on claim |
| **61** | HIPPS RUGS DOS billed dollars | HH PPS and RUGS DOS billed amount should not have a dollar amount. |
| **62** | HIPPS RUG requires rehab | HIPPS RUG rate code requires rehabilitation therapy |
| **63** | Submit EOB | Please resubmit with a EOB in order to complete the processing of the claim |
| **64** | Duplicate service code | Duplicate service code on same claim with no modifier. Please resubmit with corrected modifier on claim. |
| **65** | Incorrect From DOS | Please resubmit with corrected From DOS on claim. |
| **66** | Incorrect To DOS | Please resubmit with corrected TO DOS on claim. |
| **67** | Incorrect Admit Type | Please resubmit with a correct Admit Type on claim. |
| **68** | Incorrect HIPPS code | Please resubmit with corrected HIPPS code on IRF claim. |
| **69** | Incorrect IRF charges | Please resubmit with corrected charges on IRF claim |
| **70** | Incorrect Rev code/HCPC rate | Please resubmit with corrected Revenue Code and HCPCS/Rate on claim |
| **71** | Invalid claim line units | Claim line units not equal to days reflected with span code 74 |
| **72** | Annual benefit amount exceeded | Annual benefit amount exceeded |
| **73** | Lifetime benefit amount exceeded | Lifetime benefit amount exceeded |
| **74** | Individual Lifetime visits exceeded | Individual Lifetime visits exceeded |
| **75** | Not covered | This service is not a covered benefit under the plan for this date of service. |
| **76** | Benefit visit limit exceeded | Benefit visit limit exceeded |
| **77** | Benefit dollar limit exceeded | Benefit dollar limit exceeded |
| **78** | Excluded from provider contract | This service is excluded from the Provider's contract. Reimbursement will be made only on services covered by the contract. |
| **79** | Duplicate Mem/DOS/Service Code/Pay To/Modifier | Duplicate Mem/DOS/Service Code/Pay To/Modifier |
| **80** | Dup mem/DOS/Svc Code/ Pay To/Rend Phys/Mod | Duplicate member/DOS/Service Code/ Pay To/Rendering Physician/Modifier |

| Denial Code | Description | Denial Language |
|---|---|---|
| **81** | One 0024 revenue code is permitted per claim | Per CMS guidelines, only one 0024 revenue code is permitted per claim |
| **82** | Resubmit with appropriate diagnosis codes. | Please resubmit the claim with appropriate diagnosis codes. |
| **83** | Duplicate claim line | Duplicate claim line (same provider/member/DOS/CPT(REV) |
| **84** | Not covered/Not allowable by contract | Service not covered/Not allowable by contract for provider. |
| **85** | Duplicate Claim (Provider/Member/DOS) | Duplicate Claim (Provider/Member/DOS) |
| **86** | No RAP | A Request for Anticipated Payment (RAP) has not yet been submitted for this episode. A RAP must be submitted before payment can be made on the final claim of the episode. |
| **87** | Unmatched HIPPS | The HIPPS code that was submitted on the RAP for this episode does not match the HIPPS code that was billed on the final claim. Please resubmit a corrected claim or RAP. |
| **88** | No RAP 2 | A Request for Anticipated Payment (RAP) has not yet been submitted for this episode. A RAP must be submitted before payment can be made on the final claim of the episode. |
| **89** | Invalid from date | The From statement date must equal the date on the service line item. Please submit a corrected claim. |
| **90** | The statement From date is a required field. | The statement From date is a required field. Please resubmit a corrected claim. |
| **91** | Duplicate RAP | A Request for Anticipated Payment (RAP) has already been submitted for this episode. A cancellation of the original RAP must be submitted before payment can be made on a corrected RAP. |
| **92** | RAP date discrepancy | The statement From and Through date on the Request for Anticipated Payment (RAP) should be equal. Please submit a corrected claim. |
| **93** | Include rev and HCPC codes for each service. | Please resubmit the claim and include both valid revenue and HCPC codes for each service. |
| **94** | HIPPS RUGS DOS not in time period. | HIPPS RUGS Date of Service is not within the assessment modifier time period. |
| **95** | Not a member | Denied: No coverage effective at time of service. |
| **96** | Need EOB | Please resubmit with an Explanation of Benefits from the primary insurance carrier |
| **97** | Incorrect bill type | Please resubmit this claim with a corrected bill type |
| **98** | Incorrect number of units | Please resubmit with the correct number of units on claim. |
| **99** | Inpatient hospital days have been exhausted. | Inpatient hospital days have been exhausted. |
| **100** | Rebundled | Two or more procedure codes were rebundled into one comprehensive code. |
| **101** | Pre-op included | Pre-Operative services are included in the surgical package. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **102** | Post-op included | Post-Operative services are included in the surgical package. |
| **103** | Medical visit is not separately reimbursable. | Medical visit is not separately reimbursable. |
| **104** | One initial/3 years | Initial visit is only billed once per patient/provider every three years. |
| **105** | Duplicate claim. | Duplicate claim. |
| **106** | Incidental | Incidental service(s) to primary procedure do not require separate reimbursement - The patient is not liable for payment. |
| **107** | Obsolete or invalid procedure code | Obsolete or invalid procedure code |
| **108** | Multiple unit or multiple modifier denial. | Multiple unit or multiple modifier denial. |
| **109** | Unilateral/Bilateral procedure code | Unilateral/Bilateral procedure code |
| **110** | Mutually exclusive | Two or more procedure codes are considered mutually exclusive. |
| **111** | Procedure does not require an Assistant Surgeon. | Procedure does not require an Assistant Surgeon. |
| **112** | Age range discrepancy | Provider assigned an age-specific procedure to a patient whose age is outside of the designated age range. |
| **113** | Gender discrepancy | Provider assigned a gender-specific procedure to a patient of the opposite sex. |
| **114** | Invalid diagnosis code | Invalid diagnosis code |
| **116** | OPPS | The services reported on this claim are not separately reimbursable under OPPS. |
| **117** | Incorrect blood | Line items billing for blood and products is incorrect. Please resubmit a corrected claim. |
| **118** | Radiopharm | Certain nuclear medicine procedures are performed with specific diagnostic radiopharmaceuticals. The required radiopharmaceutical is not present on the claim. Please resubmit corrected claim. |
| **119** | G0739 | G0379 must be billed in conjunction with G0378. |
| **120** | Inc in Part A | The services billed on this claim are considered directly related to an inpatient admission and are not separately billable. These services are included in the Part A payment. |
| **121** | Need mod | Component of comprehensive procedure that would be allowed if appropriate modifier were present |
| **122** | T or S | Medical visit on same day as a type T or S procedure without modifier 25. |
| **123** | Rev Code | Please resubmit with corrected Revenue Code. |
| **124** | Mileage | Mileage included in base rate. |
| **125** | Invoice | Submit claim with invoice. |
| **126** | Total mismatch | Claim total does not match detail line total. |
| **127** | Diag required | Per CMS regulations this benefit requires specific diagnosis codes. |
| **128** | EOB required | The primary carrier's explanation of benefits is necessary to consider these services. |
| **129** | Single HIPPS | Effective January 1, 2008, episodes paid under the refined HH PPS will be paid based on a single HIPPS code. Please submit a corrected claim. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **130** | Missing Modifier | Please resubmit with appropriate or missing modifier. |
| **131** | Rendering Provider | Rendering Provider Required on Claim |
| **132** | POA | Please resubmit with a valid POA code |
| **133** | SUBMITTED W/O NDC NUMBERS | Please resubmit with National Drug Code (NDC) numbers. |
| **134** | SUBMITTED W/INVALID NDC #S | Please resubmit with a valid National Drug Code (NDC) number. The number submitted is not valid. |
| **135** | INVALID NDC NUMBER | Please resubmit with a valid National Drug Code (NDC) number. The number submitted is not valid. |
| **136** | NDC NUMBER(S) ILLEGIBLE | Please resubmit this claim with legible NDC numbers. |
| **137** | FIN and NPI mismatch | Our data indicates a FIN and NPI mismatch as billed. Please submit a corrected claim. |
| **138** | Acute Rehab | This is an acute rehab admit. Please resubmit claim with the appropriate case mix group code. |
| **139** | OON | The benefit for this service is not covered out of network. |
| **140** | Add On | Add-on billed without primary code. |
| **141** | Drug Coverage Only | No Medical Coverage. Member has Drug Coverage Only. |
| **142** | Bundled Service | Bundled Service |
| **143** | HIPPS | A HIPPS codes is required for this type of claim. Please resubmit with appropriate coding. |
| **144** | A8A9 | Please resubmit claim with value codes A8 & A9 |
| **146** | Old | Services not billable for the Fiscal Year. |
| **147** | OPPS | Code not recognized by OPPS; alternate code for the same service may be available. |
| **148** | CMS | Code not recognized by CMS; alternate code for the same service may be available. |
| **149** | Not enrolled | Member not enrolled on DOS. |
| **150** | Not enrolled group | Member was not enrolled with this Medical Group on DOS . |
| **151** | Bill on 1500 | Resubmit ASC Claims on HCFA ASCs are required to submit claims on form CMS-1500. Please resubmit claim on appropriate form. |
| **152** | RUGS | Submit with RUGS code. |
| **153** | DevCode | Claim lacks required device code. |
| **154** | Report | Code is used for reporting performance measurements only. |
| **155** | Invalid | G/I- This service code is not valid for Medicare purposes. Medicare uses an alternate code for the reporting and payment of these services. Please resubmit claim with appropriate coding. |
| **156** | Excl | E- This service code is excluded from the Physician fee schedule by regulation. No payment is made under the MPFS for this code. |
| **157** | No RVU | J- This code has no Relative Value Unit and no payment amount. The intent of this code is to facilitate the identification of anesthesia services only. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **158** | APC | Reimbursement for this service is included in the APC reimbursement. |
| **159** | DRG | Payment for this service is included in the DRG rate. |
| **160** | Age | The diagnosis code includes an age range and the age is outside that range. |
| **161** | Gender | The diagnosis code includes sex designation and the sex does not match. |
| **162** | E Dx | The first letter of the principle diagnosis code in an E. This edit is not applicable to the admit diagnosis. |
| **163** | Gender Match | The sex of the patient does not match the sex designated for the procedure on the record. |
| **164** | Bilateral 2x | The same bilateral procedure code occurs two or more times on the same service date. |
| **165** | Bilateral 2xx | The same bilateral procedure code occurs two or more times on the same service date or the same inherent bilateral procedure code occurs two or more times on the same service date. |
| **166** | Mut Excl | The procedure is one of a pair of mutually exclusive procedures in the NCCI table coded on the same day, where the use of a modifier is not appropriate. |
| **167** | No Mod | The procedure is identified as part of another procedure on the claim coded on the same day, where the use of a modifier is not appropriate. |
| **168** | No Blood | A blood transfusion or exchange is coded but no blood product is coded. |
| **169** | Obs | A 762 (observation) revenue code is used with a HCPCS other than observation (99217-99220, 99234-99236, G0378, G0379). |
| **170** | HCPCS Req | Revenue center requires HCPCS. |
| **171** | Comp EM | Composite E/M conditions not met for observation and line item. |
| **172** | Inv Rev | Revenue code not recognized by Medicare. |
| **173** | No Proc | Claim lacks allowed procedure code. |
| **176** | Not covered | This is not a covered service. |
| **177** | Max | Maximum out of Pocket has been reached. Eligible Amounts have been paid at 100%. |
| **178** | Max copay | Maximum copay per diem has been satisfied for this benefit period. No copay per diem applied. |
| **179** | Cosurgeon | Co-Surgeon Not Covered |
| **180** | Credit | Credit applied for prior RAP payment |
| **181** | MedSurg | This service has been down graded to Med/Surg Day |
| **182** | Skilled | This service has been down graded to Skilled Nursing |
| **183** | Subacute | This service has been down graded to Subacute |
| **184** | Telemetry | This service has been down graded to Telemetry |
| **185** | Obs 2 | This service has been down graded to the Observation Rate |
| **186** | Per Diem | This service is included in the In-patient Per Diem |
| **187** | Obs Rate | This service is included in the Observation Rate |
| **188** | Package | This service is included in the Package Price |

| Denial Code | Description | Denial Language |
|---|---|---|
| **189** | Stoploss | This service is included in the Stop Loss Rate |
| **190** | Unequal | Itemized Bill not equaled to charges |
| **191** | Missing Anes Time | Please rebill. The service is billed is missing Anesthesia Time Units |
| **192** | Missing CPT | MISSING CPT CODE |
| **193** | Mult Proc | MULTIPLE PROCEDURES BILLED WITHOUT MODIFIER |
| **194** | Mult Surg | Multiple Surgery Reduction |
| **195** | Non Par Timely | NON PAR PROVIDER TIMELY FILING |
| **196** | Not Quest Lab | NON QUEST LAB PROVIDER |
| **197** | Convenience | Patient convenience items are not covered under this benefit plan. |
| **198** | Rebill | REBILL USING MEDICARE G CODES |
| **199** | Facility Payment | Reimbursement for service is included in the payment made to the facility. |
| **200** | HH Claims | Resubmit HH Claims on UB Home Health Agencies are required to submit claims on form CMS-1450, the UB-04. Please resubmit claim on appropriate form. |
| **201** | Self Admin | Self administered drugs are not covered services under this plan. |
| **202** | SNF Exhaustted | SKILLED NURSING DAYS EXHAUSTED |
| **203** | 3 Units Blood | The first three units of blood are not covered services under this plan. |
| **204** | UR Denied Days | UR DENIED HOSPITAL DAYS |
| **205** | After Death | This date of service is after the date of the patient's death. |
| **206** | DRG Invalid | The DRG submitted on this claim is not valid for the fiscal year billed. Please resubmit claim with a corrected DRG. |
| **207** | ER in 72 hrs | Emergency Room visits within 72 hours of an inpatient admission cannot be billed and reimbursed separately. |
| **208** | Inc in case | This service is included in the Case Rate |
| **209** | Inc in CMG | Reimbursement for this service in included in the CMG |
| **210** | Denied Days | These hospital days have been denied by our Health Services Department. |
| **211** | Spec Dx | Payment for this benefit requires specific diagnosis codes per CMS guidelines. |
| **212** | Dup | This is a duplicate of a claim that was previously adjudicated. |
| **213** | Location | Service Facility Location Required. |
| **214** | Adjust for Cap | This claim is an adjustment for services capitated incorrectly according to your contract. |
| **215** | BT 710 | Payment for claims submitted using bill type 710 will be $0.00 as this is a non-payment claim. |
| **216** | Excl | Excluded Service Not Covered |
| **217** | NotMember2 | Denied: No coverage effective at time of service. |
| **220** | Qual | Physician Quality Reporting Indicator codes are for reporting purposes only and are not eligible for reimbursement. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **221** | Item Bill | Itemized Bill Request: Itemized bills can be faxed to 1(877)-788-2764 |
| **223** | ASC | INCLUDED IN ASC RATE |
| **224** | CG | CLAIMSGUARD ADJUSTMENT |
| **225** | Inc | Included in other procedure. |
| **226** | Dup | Duplicate Line on Same Claim |
| **227** | IncPay | Service included in payment for surgical procedure. |
| **228** | NoCov | Denied: No coverage effective at time of service. |
| **230** | PHP | The required Bravo Personal Health Profile Form was not received or was incomplete. Please submit completed/corrected form. |
| **231** | Cap | This is a capitated service |
| **232** | Therapy | Please resubmit with the appropriate code to reflect the correct amount of therapies billed. |
| **233** | Insuf Svc | Insufficient services on a day of a partial hospitalization. |
| **301** | Admit Hour | Please resubmit with a valid admit hour. |
| **302** | Bill Type | Please resubmit claim with appropriate bill type for inpatient procedure. |
| **303** | Multiple NPI | Our data indicates this claim has multiple Rendering NPI Numbers. Please submit a corrected claim. |
| **304** | Inpt Proc | Inpatient Procedure |
| **305** | Dialysis Claim lacking CBSA | Dialysis claims require a CBSA. Please resubmit. |
| **306** | Invalid CPT for benefit | This CPT code is not valid for this benefit. Resubmit claim with Medicare approved code for benefit. |
| **307** | RAP received | RAP received. Payment for this episode has been paid. |
| **308** | Mbr not approved for in home podiatry. | This member is not approved to receive podiatry services in the home. No fee-for-service payment will be made. |
| **309** | Inpt claim with same DOS as ER | Inpatient claim/auth exists for same DOS as ER claim. |
| **310** | Code not recognized by OPPS | Codes not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, 14x). Not paid under OPPS. |
| **311** | Operating Physician required | Operating Physician Information Required. |
| **312** | HomeHealth claim for prev episode not submitted | Payment Denied. Previous Episode Final Not Submitted. |
| **313** | HIPPS/RUGS charges not equal to $0 | HIPPS/RUGS billed charges should equal zero. |
| **314** | Invalid RAP | Invalid/Incorrect RAP submitted for this episode. Valid/Corrected RAP must be submitted before FINAL can pay |

| Denial Code | Description | Denial Language |
|---|---|---|
| **315** | Submit TOB 328 to cancel paid final claim | Unable to cancel RAP because FINAL has PAID. TOB 328 must be submitted in order to cancel a paid FINAL. |
| **316** | Rendering provider name required | Individual provider name needed. Please resubmit with corrected information. |
| **317** | Max rental period exceeded | Based on Medicare pricing guidelines, the rental units have exceeded the maximum rental period of 13 months. The member now owns the equipment. |
| **318** | Attending physician NPI missing | Attending Physician with identifying NPI is a required field on Home Health claims. Please resubmit with corrected information. |
| **319** | TOB 327 for denied claim | Unable to process 327 bill type for a previously DENIED claim. |
| **320** | Date required for line item | BILL WITH SPECIFIC DATES |
| **321** | Resubmitted Claim | Duplicate of claim in review |
| **322** | Invalid date | INVALID DATE OF SERVICE |
| **323** | Cosurgeon not allowed | Co-surgeon not allowed |
| **324** | Episode canceled | Bill type 328 received; episode and associated claims cancelled. |
| **325** | Pay to provider does not match Bravo affiliations | The name in box 33 does not match what Bravo has on file. Please resubmit this claim. |
| **326** | Group TIN submitted | The Tax ID submitted is associated to a Group. Please resubmit this claim with your individual Tax ID. |
| **327** | Signature does not match what is on file | The signature on the claim does not match the signature Bravo has on file. Please resubmit this claim. |
| **328** | Submit to Part D | Please submit to your Pharmacy Program. |
| **329** | Noncovered OON dental | Dental Services Performed by Non-Par Specialists are Not Covered |
| **330** | E code cannot be principal DX | E code cannot be used as principal diagnosis. |
| **331** | Payment for non Medicare covered services | Additional payment for services not provided by Medicare. |
| **332** | Place of service not covered under OPPS | Code indicates a site of service not included in OPPS. |
| **333** | Service unit out of range for procedure | Service unit out of range for procedure. |
| **334** | invalid age | Invalid age for service provided |
| **335** | invalid sex | Invalid sex |
| **336** | Mental Health dx required | Partial hospitalization service for non-mental health diagnosis. |
| **337** | Only therapy services provided | Only activity therapy and/or occupational therapy services provided. |
| **338** | Invalid units for bilateral procedure | Terminated bilateral procedure or terminated procedure with units greater than one. |
| **339** | Implanted dev code & administered sub do not match | Inconsistency between the implanted device or the administered substance and the implantation or associated procedure. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **340** | Inpt procedures not payable | Inpatient separate procedures not paid. |
| **341** | Multiple codes for same service | Multiple codes for same service. |
| **342** | Invalid dx for clinical trial | Clinical trial requires diagnosis codes V707 as other than primary diagnosis. |
| **343** | Modifier CA billed for multiple procedures | Use of modifier CA with more than one procedure not allowed. |
| **344** | Invalid service for OT code | This OT code only billed on partial hospitalization claims. |
| **345** | Invalid service for AT code | AT service not payable outside the partial hospitalization program. |
| **346** | Service not FDA approved | Service provided prior to FDA approval. |
| **347** | Service not approved by NCD | Service provided prior to date of National Coverage Determination (NCD) approval. |
| **348** | Service provided outside approval period | Service provided outside approval period. |
| **349** | Invalid pt status for CA modifier | CA modifier requires patient status code 20. |
| **350** | Billed amt cannot exceed $1.01) | Charge exceeds token charge ($1.01). |
| **351** | Invalid condition code for bill type | Partial hospitalization condition code 41 not approved for type of bill. |
| **352** | Claim does not meet obs criteria | Observation does not meet minimum hours, qualifying diagnoses, and/or 'T' procedure conditions. |
| **353** | Invalid bill type for observation | Observation G codes only allowed with bill type 13x. |
| **354** | Non-reportable for site of service | Non-reportable for site of service. |
| **355** | E/M conditions not met for observation criteria | E/M conditions not met and line item date of obs code G0244 is not 12/31 or 01/01. |
| **357** | Incorrect billing of modifier FB or FC. | Incorrect billing of modifier FB or FC. |
| **358** | Invalid code for place of service | Mental health code not approved for partial hospitalization. |
| **359** | Invalid code for place of service | Mental health service not payable outside the partial hospitalization program. |
| **360** | Service provided outside approval period | Service provided on or after effective date of NCD non-coverage. |
| **361** | Not a covered Medicaid benefit | The patient does not have benefits for this service under this Medicaid Plan. |
| **365** | Medical documentation required | Please resubmit claim with the appropriate medical documentation. |
| **369** | No OON Medicaid coverage for this benefit | The benefit for this service is not covered out of network service for this Medicaid Plan. |
| **370** | Code billed in excess of once per 90 period | Report only once every 90 days per CPT. |
| **371** | TOB 328 received with no matching claim in history | 328 Received. No matching claim found for cancellation request. Cancellation request must match claim on file. |
| **372** | Invalid admin code | Resubmit with appropriate administration code. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **373** | Submit to ASH | This claim is the responsibility of Bravo Health's Delegated Chiropractor Vendor. This claim has been forwarded on your behalf. |
| **374** | Service paid previously to another provider. | Payment Denied. Information on file indicates services are provided by another provider. |
| **375** | Incorrect Admission Source | Please submit with correct Admission Source. |
| **376** | CMS Noncovered ICD9/CPT Mods billed | This claim has been denied for payment since it contains one or more of the ICD-9 codes or CPT modifiers CMS has identified as not eligible for payment. |
| **377** | Resubmit proc code | Please resubmit with a specific procedure code. |
| **378** | Resubmit claim form | Please resubmit claim on the correct claim form type. |
| **379** | Invalid ASC Code | The service billed is not an approved ASC procedure. |
| **380** | Invalid Date Span | The "from" and "to" dates must be different. |
| **381** | IB fax number | Please fax bills to 1(877)-788-2764. |
| **382** | Invalid DRG | No DRG found for the codes used. |
| **383** | Invalid secondary diagnosis | Invalid secondary diagnosis code. |
| **384** | Invalid discharge date | Invalid discharge date. |
| **385** | Global day overlap | Not reimbursable. Services rendered are within the global day billing period. |
| **386** | HHDisenroll | This member disenrolled during the home health episode. A claim for a partial episode payment must be submitted in order for charges to be adjudicated properly. |
| **387** | BPHP previously paid | The Bravo Personal Health Profile has already been reimbursed for this member for the current calendar year. |
| **388** | Claim cancelled | Bill Type 118 received and claim was cancelled. |
| **389** | Leave of Absence and Level of Care mismatch | Leave of Absence and Level of Care cannot be billed with same Date of Service |
| **390** | Service cannot be billed on same date as LOC | Code cannot be billed without Level of Care on same Date of Service |
| **393** | Invalid Discharge Status | Invalid Discharge Status |
| **998** | Negative Check | This amount has been credited to a prior adjustment. |
| **999** | Reversed Claim | This claim represents an adjustment to claim ___ processed on mm/dd/yyyy. |
| **1001** | MUE Edit | The units of service billed exceeds our acceptable maximum units (MUE-medically unlikely edits) |
| **1002** | Incorrect TOB ESRD | Hospitals with a Medicare certified renal dialysis facility should have outpatient ESRD related services billed by the hospital-based renal dialysis facility on bill type 72x. |
| **1003** | EOP Required | Please resubmit with a copy of the Explanation of Payment from the primary carrier. |
| **1004** | MSP | This claim has been paid in full by the primary carrier. |
| **1005** | HH Treatment Code not billed | 18 digit Alpha/Numeric MCR Treatment Authorization code not present on claim. Please resubmit claim. |
| **1006** | Resubmit with RUGs code | Resubmit claim with valid RUGS code. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1007** | Multiple rev code 0023 | Multiple instances of revenue code 0023 billed on a single claim. |
| **1008** | Missing or invalid Admit Date | Admit date is missing or invalid. |
| **1009** | Negative charges not allowed | Negative charges are not permitted on a claim service line |
| **1011** | Team surgeon not allowed | Team surgeon not allowed. |
| **1012** | HCPCS required | Surgical procedure requires HCPCS. |
| **1013** | Benefit not separately reimbursed | This benefit is not separately reimbursed. |
| **1014** | Member not within age range for benefit | The benefit for the service rendered is not within the age range for the member. |
| **1015** | Only one anesthesia code per surgical session | Only one primary anesthesia should be reported for a surgical session. |
| **1017** | Service Not Covered | Service Not Covered |
| **1018** | Missing EMS report | Need ambulance EMS report. |
| **1019** | Invalid anesthesia code | Need valid anesthesia code. |
| **1020** | Admit date under previous contract | Service dates not matching proper 60 Day Episodic span from Start of Care, Admit date under previous contract. Services reimbursed under previous contract due to Admit date |
| **1021** | Missing form | A single case agreement referral form must accompany each claim submitted. |
| **1023** | Missing OP report | Resubmit with OP report. |
| **1024** | Invalid discharge hour | Invalid Discharge Hour |
| **1025** | ERAP payment | Payment denied. Information on file indicates payment was made to another provider. |
| **1026** | Units billed exceeds auth | The number of units billed exceeds the number of units authorized. |
| **1027** | Refund received due to billing error | Refund received due to billing error |
| **1028** | Refund Received resubmit to LifeSynch | Refund Received resubmit to LifeSynch |
| **1029** | Raytel and service location not in box 33 | Please resubmit using Raytel's Tax ID and the service location along with Raytel's name in box #33. |
| **1030** | Invalid primary or admitting dx code | Invalid primary or admitting diagnosis code – please resubmit with appropriate Dx code |
| **1031** | Primary dx paired with secondary dx | Primary Dx is not acceptable unless paired with appropriate secondary Dx |
| **1032** | Billable visit not appropriate level | First billable visit not skilled at appropriate level |
| **1033** | Supply revcodes not on claim | Provider billed HHPPS FINAL indicating Medical/Surgical supplies. Supply Revenue Code 027x and/or 062x not present on claim. Please resubmit corrected claim |
| **1034** | Revcode requires HCPCS, DOS and amount | Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1035** | Cancellation submitted prior to up/downcoding | In order to bill new HHPPS HHRG code, a 328 cancellation needs to be submitted to cancel current HHPPS HHRG code on file before new up coded or down coded HHRG/HHPPS code can be billed. |
| **1036** | Unable to adjust RAPS | Unable to adjust RAPS. RAPS must be canceled and re-billed in order to correct information on file. |
| **1037** | No claim in std benefit period | No claim in std benefit period before use of reserve days |
| **1038** | Other agency responsible for payment | Other agency may be responsible for payment |
| **1040** | Timely filing | This claim was submitted after the filing deadline. |
| **1046** | Invalid specialty for svc | Provider specialty invalid for service rendered. |
| **1049** | Resubmit to TX Mcaid , MCO not responsible for InP | Submit Inpatient Acute Care Claims to TMHP. |
| **1050** | MOOP | This member has reached the max out-of-pocket amount for 2011. If cost-share in excess of what is shown on the EOP has been collected, please reimburse the difference to the member. |
| **1051** | Medicare not reimbursing procedure code | This procedure code is not reimbursable through Medicare. Please resubmit with a valid code. |
| **1052** | Not medically necessary | Medical necessity not established for services rendered. |
| **1053** | Attendant Care Payment | Based upon Participation Level, Attendant Care Enhanced Payment is included in claim payment. |
| **1054** | Resubmit with CMS rate sheet | Resubmit claim with a CMS rate sheet. |
| **1055** | Cancellation recd, claim cancelled. | The cancellation claim was received; claim was cancelled. |
| **1056** | 327 recd; adjustment adjudicated | TOB 327 received; adjustment adjudicated. |
| **1057** | Billed service to DMERC | Service can only be billed to the DMERC. |
| **1058** | Denied for wrong surgery | Claim detail denied due to wrong surgery performed on client |
| **1059** | Pending Rate Hearing | State has not issued procedure code pricing. Claims will be reprocessed when State issues rates. |
| **1060** | ICRS DRG audit | Claim reversal is due to ICRS DRG audit. |
| **1061** | Resubmit with a DRG | Please resubmit your claim with a DRG. |
| **1062** | Code is Included | Services included per CPT Guidelines. |
| **1064** | CODE CHANGED | PROCEDURE CODE CHANGED PER REVIEW |
| **1065** | INCLUDED IN PRIMARY PROCEDURE | INCLUDED IN PRIMARY PROCEDURE |
| **1066** | PROCEDURE INAPPROPRIATELY CODED | PROCEDURE INAPPROPRIATELY CODED |
| **1067** | NOT A COVERED SERVICE | NOT A COVERED SERVICE |
| **1068** | NOT A COVERED SERVICE FOR PROVIDER SPECIALTY | NOT A COVERED SERVICE FOR PROVIDER SPECIALTY |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1069** | POST-OP FOLLOW-UP INCLUDED WITH GLOBAL FEE | POST-OP FOLLOW-UP INCLUDED WITH GLOBAL FEE |
| **1070** | E & M CODE LEVEL RECODED. | E & M CODE LEVEL RECODED. |
| **1071** | RESUBMIT WITH SUPPORTING DOCUMENTATION | RESUBMIT WITH SUPPORTING DOCUMENTATION |
| **1072** | MULTIPLE ENDOSCOPY RULES | MULTIPLE ENDOSCOPY RULES |
| **1073** | SURGEON AND SURGICAL ASSIST | SURGEON AND SURGICAL ASSIST CANNOT BE THE SAME PROVIDER |
| **1074** | ICD9 DOES NOT SUPPORT PROCEDURE | THE ICD9 CODES ON THE CLAIM DO NOT SUPPORT THE BILLED PROCEDURE CODE |
| **1075** | ONLY ONE E/M CODE ALLOWED PER DAY | ONLY ONE E/M CODE ALLOWED PER DAY |
| **1076** | INCORRECT MODIFIER | INCORRECT MODIFIER |
| **1077** | MULTIPLE ASSIST SURGEONS NOT ALLOWED | MORE THAN ONE ASSISTANT SURGEON NOT ALLOWED |
| **1078** | INCLUDED IN E&M SERVICE | INCLUDED IN E&M SERVICE |
| **1079** | MUTUALLY EXCLUSIVE PROCEDURE | MUTUALLY EXCLUSIVE PROCEDURE |
| **1080** | ONLY ONE SERVICE ALLOWED PER COURSE OF TREATMENT. | ONLY ONE SERVICE ALLOWED PER COURSE OF TREATMENT. |
| **1081** | ALLOWED AMOUNT GREATER THAN SUBMITTED AMOUNT | ALLOWED AMOUNT GREATER THAN SUBMITTED AMOUNT |
| **1082** | ADD-ON CODE WAS DENIED | THE ADD-ON CODE WAS DENIED BECAUSE THE PRIMARY PROCEDURE WAS NOT PAID OR WAS NOT IDENTIFIED ON THE CLAIM. |
| **1083** | ADJUSTED UNITS | ADJUSTED UNITS BECAUSE THEY EXCEEDED THE AMOUNT ALLOWED |
| **1084** | RECODED TO A GENERAL ANESTHESIA SERVICE CODE | RECODED TO A GENERAL ANESTHESIA SERVICE CODE |
| **1085** | BLOOD COLLECTION INCLUDED IN LAB SERVICES | BLOOD COLLECTION INCLUDED IN LAB SERVICES |
| **1086** | SERVICE PROCESSED AS A BILATERAL PROCEDURE | SERVICE PROCESSED AS A BILATERAL PROCEDURE |
| **1087** | BILATERAL PROCEDURE INAPPROPRIATELY CODED | BILATERAL PROCEDURE INAPPROPRIATELY CODED |
| **1088** | PROCEDURE BILATERAL IN NATURE | PROCEDURE BILATERAL IN NATURE |
| **1089** | SERVICE DENIED | SERVICE DENIED BECAUSE THE RELATED OR QUALIFYING SERVICE WAS NOT PAID OR IDENTIFIED |
| **1090** | THIS SERVICE IS BUNDLED | THIS SERVICE IS BUNDLED INTO SERVICES NOT OTHERWISE SPECIFIED |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1091** | RENTAL CAP EXCEEDED | RENTAL CAP EXCEEDED |
| **1092** | NCCI DENIAL FOR COMPREHENSIVE/COMPONENT PROCEDURE | NATIONAL CORRECT CODING INITIATIVE DENIAL FOR COMPREHENSIVE/COMPONENT PROCEDURES |
| **1093** | NCCI DENIAL FOR MUTUALLY EXCLUSIVE PROCEDURES | NATIONAL CORRECT CODING INITIATIVE DENIAL FOR MUTUALLY EXCLUSIVE PROCEDURES |
| **1094** | NATIONAL CORRECT CODING POLICY MANUAL GUIDELINE | NATIONAL CORRECT CODING POLICY MANUAL GUIDELINE |
| **1095** | CLINICAL TRIAL REQUIRES APPROPRIATE DIAGNOSIS | CLINICAL TRIAL REQUIRES APPROPRIATE DIAGNOSIS |
| **1096** | COMPONENT OF CRITICAL CARE SERVICE | COMPONENT OF CRITICAL CARE SERVICE |
| **1097** | CO-SURGEONS CANNOT BE SAME SUBSPECIALTY | CO-SURGEONS CANNOT BE SAME SUBSPECIALTY |
| **1098** | REDUCTION FOR IONIC CONTRAST MEDIA | REDUCTION FOR IONIC CONTRAST MEDIA |
| **1099** | EXCEEDS COVERAGE GUIDELINES | EXCEEDS COVERAGE GUIDELINES |
| **1100** | INVALID AGE FOR SERVICE PROVIDED | INVALID AGE FOR SERVICE PROVIDED |
| **1101** | CPT RECODED TO A CMS DESIGNATED ALTERNATE HCPCS C | CPT RECODED TO A CMS DESIGNATED ALTERNATE HCPCS CODE |
| **1102** | HCPCS RECODED BASED ON AGE | HCPCS RECODED BASED ON AGE |
| **1103** | GENDER-SPECIFIC PROCEDURE | PRIOVIDER ASSIGNED A GENDER-SPECIFIC PROCEDURE TO A PATIENT OF THE OPPOSITE SEX |
| **1104** | HCPCS RECODED BASED ON GENDER | HCPCS RECODED BASED ON GENDER |
| **1105** | INCLUDED IN GLOBAL FEE | INCLUDED IN GLOBAL FEE |
| **1106** | CPT CODE NOT VALID FOR DOS | CPT CODE NOT VALID FOR THIS DATE OF SERVICE. PLEASE RESUBMIT WITH VALID CPT CODE. |
| **1107** | CONVENIENCE ITEM - DOES NOT MEET DEFINITION OF DM | CONVENIENCE ITEM - DOES NOT MEET DEFINITION OF DME |
| **1108** | SERVICE CAN ONLY BE BILLED TO DMERC | SERVICE CAN ONLY BE BILLED TO DMERC |
| **1109** | DUPLICATE SERVICE WITHIN 30 DAYS | DUPLICATE SERVICE WITHIN 30 DAYS |
| **1110** | DUPLICATE SERVICE ON SAME DAY | DUPLICATE SERVICE ON SAME DAY |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1111** | DIAGNOSIS INAPPROPRIATE FOR AGE | DIAGNOSIS INAPPROPRIATE FOR AGE |
| **1112** | DIAGNOSIS INAPPROPRIATE FOR GENDER | DIAGNOSIS INAPPROPRIATE FOR GENDER |
| **1113** | PRINCIPAL DIAGNOSIS INAPPROPRIATELY CODED | PRINCIPAL DIAGNOSIS INAPPROPRIATELY CODED |
| **1114** | E & M LEVEL OF SERVICE RECODED | E & M LEVEL OF SERVICE RECODED |
| **1115** | E/M SERVICE INAPPROPRIATELY CODED | E/M SERVICE INAPPROPRIATELY CODED |
| **1116** | EXCEEDS CLINICAL GUIDELINES | THIS MANY SERVICES, THIS LENGTH OF SERVICE, THIS DOSAGE OR THIS DAY'S SUPPLY EXCEEDS CLINICAL GUIDELINES |
| **1117** | EXPERIMENTAL/INVESTIGATIONAL | PROCEDURE/TREATMENT IS DEEMED EXPERIMENTAL/INVESTIGATIONAL |
| **1118** | THIS DATE OF SERVICE IS AFTER THE PATIENT'S DEATH | THIS DATE OF SERVICE IS AFTER THE PATIENT'S DEATH |
| **1119** | RESUBMIT WITH APPROPRIATE MEDICARE G CODE | RESUBMIT WITH APPROPRIATE MEDICARE G CODE |
| **1120** | ADJUSTMENT | ADJUSTMENT FOR COMPONENT OF PROFESSIONAL, TECHNICAL OR GLOBAL SERVICES |
| **1121** | PARTIAL HOSPITALIZATION REQUIRES MENTAL HEALTH DI | PARTIAL HOSPITALIZATION REQUIRES MENTAL HEALTH DIAGNOSES. |
| **1122** | INCLUDED IN PHYSICAL MEDICINE SERVICE | INCLUDED IN PHYSICAL MEDICINE SERVICE |
| **1123** | INCLUDE IN MONTHLY RENTAL FEE | INCLUDE IN MONTHLY RENTAL FEE |
| **1124** | INCLUDED IN OTHER CODE | INCLUDED IN OTHER CODE |
| **1125** | PROCEDURE CODE IS AN "INCIDENT TO" SERVICE | PROCEDURE CODE IS AN "INCIDENT TO" SERVICE |
| **1126** | REIMBURSEMENT FOR SERVICE IS INCLUDED | REIMBURSEMENT FOR SERVICE IS INCLUDED IN THE PAYMENT MADE TO THE FACILITY |
| **1127** | PLEASE CODE ICD9 TO HIGHEST LEVEL | PLEASE CODE ICD9 TO HIGHEST LEVEL OF SPECIFICITY USING 4TH AND 5TH DIGITS. |
| **1128** | MODIFIER INAPPROPRIATE FOR PROCEDURE | MODIFIER INAPPROPRIATE FOR PROCEDURE |
| **1129** | SERVICE PART OF AN INPATIENT ONLY PROCEDURE | SERVICE PART OF AN INPATIENT ONLY PROCEDURE |
| **1130** | INVALID REVENUE CODE | INVALID REVENUE CODE |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1131** | SEPARATE PROCEDURES NOT SEPARATELY PAYABLE | SEPARATE PROCEDURES NOT SEPARATELY PAYABLE |
| **1132** | IMPLANT PROCEDURE REQUIRES IMPLANT DEVICE | IMPLANT PROCEDURE REQUIRES IMPLANT DEVICE |
| **1133** | EXCEED LAB PANEL PRICE | PRICE OF LAB PANEL COMPONENTS EXCEED LAB PANEL PRICE |
| **1134** | RECODED TO THE LEAST COSTLY ALTERNATIVE | RECODED TO THE LEAST COSTLY ALTERNATIVE |
| **1135** | MODIFIER REMOVED | MODIFIER REMOVED, TERMINATED PROCEDURE CANNOT BE BILLED BILATERALLY |
| **1136** | SITE OF SERVICE DIFFERENTIAL | SITE OF SERVICE DIFFERENTIAL |
| **1137** | MULTIPLE ENDOSCOPY REVIEW | MULTIPLE ENDOSCOPY REVIEW |
| **1138** | OUTPATIENT MENTAL HEALTH TREATMENT | OUTPATIENT MENTAL HEALTH TREATMENT LIMITATION APPLIED |
| **1139** | MODIFIER INAPPROPRIATELY CODED | MODIFIER INAPPROPRIATELY CODED |
| **1140** | CPT MODIFIER IS NOT VALID | CPT MODIFIER IS NOT VALID |
| **1141** | MODIFIER CA ONLY ALLOWED ONCE PER DOS | MODIFIER CA ONLY ALLOWED ONCE PER DATE OF SERVICE |
| **1142** | MODIFIER DENOTES FULL OR PARTIAL DEVICE CREDIT | MODIFIER DENOTES FULL OR PARTIAL DEVICE CREDIT |
| **1143** | MODIFIERS RE-ORDERED | MODIFIERS RE-ORDERED |
| **1144** | SERVICE CODE IS INCONSISTENT | THE SERVICE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING |
| **1145** | MODIFIER INAPPROPRIATE FOR PROVIDER TYPE | MODIFIER INAPPROPRIATE FOR PROVIDER TYPE |
| **1146** | MODIFIER INAPPROPRIATE FOR PLACE OF SERVICE | MODIFIER INAPPROPRIATE FOR PLACE OF SERVICE |
| **1147** | MODIFIER ADJUSTMENT | MODIFIER ADJUSTMENT |
| **1148** | ONLY ONE ANESTHESIA SERVICE PER OPERATIVE SESSION | ONLY ONE ANESTHESIA SERVICE PER OPERATIVE SESSION |
| **1149** | MULTIPLE NUCLEAR MEDICINE STUDIES | MULTIPLE NUCLEAR MEDICINE STUDIES |
| **1150** | MULTIPLE PROCEDURE REVIEW | MULTIPLE PROCEDURE REVIEW |
| **1151** | HCPCS CODE NOT APPROPRIATE FOR PROFESSIONAL BILLI | HCPCS CODE NOT APPROPRIATE FOR PROFESSIONAL BILLING. |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1152** | NOT COVERED FOR DIAGNOSIS INDICATED | NOT COVERED FOR DIAGNOSIS INDICATED |
| **1153** | PLACE OF SERVICE INAPPROPRIATE FOR PROCEDURE | PLACE OF SERVICE INAPPROPRIATE FOR PROCEDURE |
| **1154** | NEW PATIENT VISIT ALLOWED ONCE PER 3 YEARS | NEW PATIENT VISIT ALLOWED ONCE PER 3 YEARS |
| **1155** | MULTIPLE PHYSICIANS/ASSISTANTS | MULTIPLE PHYSICIANS/ASSISTANTS ARE NOT COVERED IN THIS CASE |
| **1156** | CO-SURGEONS NOT ALLOWED FOR THIS PROCEDURE. | CO-SURGEONS NOT ALLOWED FOR THIS PROCEDURE. |
| **1157** | NOT COVERED BY PROV IN POS | NOT COVERED WHEN PERFORMED BY THIS PROVIDER IN THIS PLACE OF SERVICE. |
| **1158** | NOT SEPARATELY REIMBURSABLE UNDER OPPS | THE SERVICES REPORTED ON THIS CLAIM ARE NOT SEPARATELY REIMBURSABLE UNDER OPPS |
| **1159** | NOT CONSIDERED SAFE AND/OR EFFECTIVE. | NOT CONSIDERED SAFE AND/OR EFFECTIVE. |
| **1160** | PROCEDURE RECODED TO DELIVERY ONLY SERVICES | PROCEDURE RECODED TO DELIVERY ONLY SERVICES |
| **1161** | DOES NOT MEET CRITERIA FOR OBSERVATION SERVICES | DOES NOT MEET CRITERIA FOR OBSERVATION SERVICES |
| **1162** | PAYABLE ONLY WITH ACTIVE INTERVENTION | PAYABLE ONLY WITH ACTIVE INTERVENTION |
| **1163** | PART OF ANOTHER PROCEDURE | THIS SERVICE IS CONSIDERED PART OF ANOTHER PROCEDURE PERFORMED ON THIS DATE AND SHOULD NOT BE BILLED AS A SEPARATE CHARGE. |
| **1164** | CODE BILLED IS NOT CORRECT/VALID | PROCEDURE CODE BILLED IS NOT CORRECT/VALID FOR THE SERVICES BILLED |
| **1165** | PROFESSIONAL COMPONENT NOT PAYABLE | PROFESSIONAL COMPONENT NOT PAYABLE FOR THIS PLACE OF SERVICE |
| **1166** | MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS CO | MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS CODE |
| **1167** | PARTIAL HOSPITALIZATION NOT INDICATED | PARTIAL HOSPITALIZATION NOT INDICATED |
| **1168** | PROCEDURE INAPPROPRIATELY CODED | PROCEDURE INAPPROPRIATELY CODED |
| **1169** | PROCEDURE INCLUDED WITH E/M SERVICE | PROCEDURE INCLUDED WITH E/M SERVICE |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1170** | PROCEDURE INVALID FOR MEDICARE PURPOSES | PROCEDURE INVALID FOR MEDICARE PURPOSES |
| **1171** | PACKAGED INCIDENTAL SERVICE | PACKAGED INCIDENTAL SERVICE |
| **1172** | CONDITION CODE NOT APPROPRIATE FOR BILL TYPE | CONDITION CODE NOT APPROPRIATE FOR BILL TYPE |
| **1173** | DUPLICATE SUBMISSION | DUPLICATE SUBMISSION |
| **1174** | DUPLICATE OF A NEW OR DELETED PROCEDURE CODE | DUPLICATE OF A NEW OR DELETED PROCEDURE CODE |
| **1175** | QUESTIONABLE SERVICE | QUESTIONABLE SERVICE |
| **1176** | INVALID ICD9 DIAGNOSIS CODE ON CLAIM. CORRECT AND | INVALID ICD9 DIAGNOSIS CODE ON CLAIM. CORRECT AND RESUBMIT. |
| **1177** | MULTIPLE PROCEDURE REDUCTION FOR RADIOLOGY | MULTIPLE PROCEDURE REDUCTION FOR RADIOLOGY |
| **1178** | INCLUDED IN RADIATION TREATMENT MANAGEMENT SERVIC | INCLUDED IN RADIATION TREATMENT MANAGEMENT SERVICE |
| **1179** | REVENUE CODE AND HCPCS DO NOT MATCH | REVENUE CODE AND HCPCS DO NOT MATCH |
| **1180** | HCPCS RECODED PER HEALTH PLAN POLICY | HCPCS RECODED PER HEALTH PLAN POLICY |
| **1181** | RECODED | RECODED TO A CODE THAT MORE ACCURATELY DESCRIBES THE SERVICES RENDERED |
| **1182** | RETURN TO OR PAYMENT ADJUSTMENT | RETURN TO OR PAYMENT ADJUSTMENT |
| **1183** | INCLUDED IN BLOOD/BLOOD PRODUCT REVENUE CODE | INCLUDED IN BLOOD/BLOOD PRODUCT REVENUE CODE |
| **1184** | REVENUE CODE DOES NOT MATCH BILL TYPE | REVENUE CODE DOES NOT MATCH BILL TYPE |
| **1185** | REVENUE CODE INAPPROPRIATELY CODED | REVENUE CODE INAPPROPRIATELY CODED |
| **1186** | REVENUE CODE REQUIRES HCPCS CODE | REVENUE CODE REQUIRES HCPCS CODE |
| **1187** | REVENUE CODE NOT RECOGNIZED BY MEDICARE | REVENUE CODE NOT RECOGNIZED BY MEDICARE |
| **1188** | SERVICE DENIED | SERVICE DENIED BECAUSE OF POTENTIAL INTERACTION WITH ANOTHER DRUG ADMINISTERED RECENTLY |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1189** | SEPARATE PAYMENT FOR SERVICES NOT PROVIDED BY MED | SEPARATE PAYMENT FOR SERVICES NOT PROVIDED BY MEDICARE |
| **1190** | CPT SEPARATE PROCEDURE POLICY | CPT SEPARATE PROCEDURE POLICY |
| **1191** | PRE AND INTRA OPERATIVE CARE | PAYMENT INCLUDES SERVICES FOR PRE AND INTRA OPERATIVE CARE |
| **1192** | SERVICE PREVIOUSLY PROCESSED | SERVICE PREVIOUSLY PROCESSED AND PAID TO THE SAME OR DIFFERENT PROVIDER |
| **1193** | SAME/SIMILAR SERVICE PERFORMED RECENTLY | SAME/SIMILAR SERVICE PERFORMED RECENTLY |
| **1194** | TECHNICAL SERVICES NOT PAYABLE FOR THIS PLACE OF | TECHNICAL SERVICES NOT PAYABLE FOR THIS PLACE OF SERVICE |
| **1195** | TEAM SURGERY NOT ALLOWED | TEAM SURGERY NOT ALLOWED |
| **1196** | TERMINATED PROCEDURE CANNOT BE BILLED BILATERALLY | TERMINATED PROCEDURE CANNOT BE BILLED BILATERALLY |
| **1197** | TECHNICAL/ PROFESSIONAL SERVICE INAPPROPRIATELY C | TECHNICAL/ PROFESSIONAL SERVICE INAPPROPRIATELY CODED |
| **1198** | Auth Modifier MisMatch | Please resubmit the claim. The modifier(s) billed on the claim do not match the modifier(s) that were authorized. |
| **1199** | No PCP assignment | CALL 1-800-291-0396 TO SELECT A PCP |
| **1200** | Referral Required | Benefit requires an authorization or referral |
| **1201** | Missing/Invalid TPI | Please resubmit with a valid Texas Provider Identification (TPI) code |
| **1202** | Provider is not certified/eligible | This provider was not certified/eligible to be paid for this procedure/service on this date of service. |
| **1203** | Included in composite rate | Services are included in composite rate |
| **1205** | Rendering NPI | Please resubmit with a Valid Billing Provider NPI |
| **1206** | Medicaid/ Copay and Deductible | This member's coverage through HealthSpring is for long-term services and supports only. |
| **1207** | Provider Mismatch | Provider name in box 33 does not match the NPI and/ or Tax Id submitted |
| **1208** | Valid Rendering NPI | Please resubmit with Valid Rendering Provider NPI |
| **1209** | C Pend 1 | The Requested EOB was not received within the allotted timeframe. |
| **1210** | C Pend 2 | The Requested Operative Note was not received within the allotted timeframe. |
| **1211** | C Pend 3 | The Requested Invoice was not received within the allotted timeframe. |
| **1212** | C Pend 4 | The Requested Itemized Bill was not received in the allotted timeframe. |
| **1213** | C Pend 5 | The Requested Referral or Authorization was not received in the allotted time frame. |
| **1214** | C Pend 6 | The Requested Medical Documentation was not received in the allotted time frame |
| **1215** | Forwarded to Well Med | Claim was forwarded to WellMed Call 1 8005507691 to check claim status. |
| **1217** | Missing Charge | Missing/Incomplete/Invalid Charges |

| Denial Code | Description | Denial Language |
|---|---|---|
| **1218** | Not Medically Necessary | NOT MEDICALLY NECESSARY |
| **1219** | ICRS DRG Audit | iCRS DRG Audit |
| **1220** | Connolly Recovery Audit | Connolly Recovery Audit |
| **1221** | Reclaim Recovery Audit | Reclaim Recovery Audit |
| **1222** | Clinical Trial Claims | CLINICAL TRIAL FILE WITH MEDICARE AND RESUBMIT AS SECONDARY |
| **1223** | Dual Eligible Acute Services | Acute Care Services are billed to the members primary Medicare plan |
| **1224** | Missing Medical Records | We requested medical records that have not been received resulting in a recoupment of monies paid |
| **1225** | TX- 2013 Claim Lines | 2013 Service Line determination and/or payment are being processed separately. Please allow additional processing time. |
| **1226** | 360 Form | 360 Form was not received or was incomplete. Please submit Completed/Corrected Form |
| **1227** | Mis-directed claim | This is a Misdirected Claim/ Service. Submit claim to Cigna LifeSource NAC Claims PO BOX 3539, Scranton, PA 18505 for repricing. |
| **1229** | Sequestration | Reduction in Federal Spending. 2% reduction in payment applied |
| **1230** | Invalid CPT/HCPC | Claim has been submitted with an invalid CPT/HCPC code. Please resubmit a corrected claim within the resubmission time frame. |
| **1264** | Service is the responsibility of the IPA. | This claim is the responsibility of and will be forwarded to the IPA. |
| **1282** | Provider is Non-Par - Point of Service benefit app | Provider is Non-Par - Point of Service benefit applied |
| **1302** | Do Not Bill Member. Coordinate benefits with the s | Do Not Bill Member. Coordinate benefits with the state. |
| **2309** | All claims for participating providers | All claims for participating providers must be submitted within the contractual timely filing limits. This claim was submitted after the filing deadline |
| **2310** | Refund | This refund was received due to an overpayment. |
| **2311** | COB | Cigna HealthSpring has no liability due to Coordination of Benefits. |