PENDED REASON CODES	
REASON CODE	**DESCRIPTION**
AGE	RESUBMIT CORRECTION - CPT CODE DOES NOT MATCH SERVICES FOR THE PATIENT AGE
ANEST	RESUBMIT CORRECTION - REQUIRE ANESTHESIA CPT CODE AND TIME TO ADJUDICATE
AP001	RESUBMIT CORRECTION - RETURN TO PROVIDER INVALID DIAGNOSIS CODE
AP002	RESUBMIT CORRECTION - RETURN TO PROVIDER DIAGNOSIS AND AGE CONFLICT
AP003	RESUBMIT CORRECTION - RETURN TO PROVIDER DIAGNOSIS AND GENDER CONFLICT
AP005	RESUBMIT CORRECTION - RETURN TO PROVIDER E-CODE AS REASON FOR VISIT
AP006	RESUBMIT CORRECTION - RETURN TO PROVIDER INVALID HCPCS PROCEDURE CODE
AP007	RESUBMIT CORRECTION - RETURN TO PROVIDER PROCEDURE AND AGE CONFLICT
AP008	RESUBMIT CORRECTION - RETURN TO PROVIDER PROCEDURE AND GENDER CONFLICT
AP014	RESUBMIT CORRECTION - RETURN TO PROVIDER SITE OF SERVICE NOT INCLUDED IN OPPS
AP015	RESUBMIT CORRECTION - RETURN TO PROVIDER SERVICES UNITS OUT OF RANGE OFR PROCEDURE
AP016	RESUBMIT CORRECTION - RETURN TO PROVIDER MULTIPLE BILATERAL PROCEDURES WITHOUT MODIFIER 50
AP017	RESUBMIT CORRECTION - RETURN TO PROVIDER INAPPROPRIATE SPECIFICATION OF BILATERAL PROCEDURE
AP018	RESUBMIT CORRECTION - LINE DENIAL INPATIENT PROCEDURE
AP021	RESUBMIT CORRECTION - ERROR DISPOSITION 01 - LINE REJECTION MEDICAL VISIT ON SAME DAY AS PROCEDURE WITHOUT MODIFIER 25
AP022	RESUBMIT CORRECTION - ERROR DISPOSITION 04 - RETURN TO PROVIDER INVALID HCPCS MODIFER
AP023	RESUBMIT CORRECTION - ERROR DISPOSITION 04 - RETURN TO PROVIDER INVALID DATE
AP024	RESUBMIT CORRECTION - ERROR DISPOSITION 03 - SUSPENSION DATE OUT OF OCE RANGE
AP025	RESUBMIT CORRECTION - ERROR DISPOSITION 04 - RETURN TO PROVIDER INVALID AGE
AP026	RESUBMIT CORRECTION - ERROR DISPOSITION 04 - RETURN TO PROVIDER INVALID GENDER
AP027	RESUBMIT CORRECTION - ERROR DISPOSITION 05 - CLAIM REJECTION RETURN TO PROVIDER ONLY INCIDENTAL SERVICES REPORTED
AP029	RESUBMIT CORRECTION - ERROR DISPOSITION 04 - RETURN TO PROVIDER PARTIAL HOSPITALIZATION SERVICE FOR NON-MENTAL HEALTH DIAGNOSIS
AP030	RESUBMIT CORRECTION - ERROR DISPOSITION 03 - SUSPENSION INSUFFICIENT SERVICES ON DAY OF PARTIAL HOSPITALIZATION
AP035	RESUBMIT CORRECTION - RETURN TO PROVIDER ONLY ACTIVITY AND/OR OCCUPATIONAL THERAPY SERVICES PROVIDED
AP037	RESUBMIT CORRECTION - RETURN TO PROVIDER TERMIANTED BILATERAL PROCEDURE OR TERMINATED PROCEDURE WITH UNITS > 1
AP038	RESUBMIT CORRECTION - RETURN TO PROVIDER INCONSISTENCY BETWEEN IMPLANT DEVICE AND IMPLANTATION PROCED URE
AP039	RESUBMIT CORRECTION - LINE REJECTION MUTUALLY EXCLUSIVE PROCEDURE, WOULD BE ALLOWED WITH APPROPRI ATE MODIFIER
AP040	RESUBMIT CORRECTION - LINE REJECTION COMPONENT OF COMPREHENSIVE PROCEDURE, WOULD BE ALLOWED WITH APPROPRIATE MODIFIER
AP041	RESUBMIT CORRECTION - RETURN TO PROVIDER INVALIED UB-92 REVENUE CODE
AP042	RESUBMIT CORRECTION - RETURN TO PROVIDER MULTIPLE MEDICAL VISITS ON SAME DAY, SAME REVENUE CODE WITHO UT CONDITION CODE G0
AP043	RESUBMIT CORRECTION - RETURN TO PROVIDER BLOOD TRANSFUTION OR BLOOD SERVICE WITHOUT SPECIFICATION OF APPROPRIATE BLOOD PRODUCT
AP044	RESUBMIT CORRECTION - RETURN TO PROVIDER OBSERVATION ROOM REVENUE CODE WITHOUT SPECIFICATION OF APPRO PRIATE OBSERVATION ROOM SERVICE
AP046	RESUBMIT CORRECTION - RETURN TO PROVIDER PARTIAL HOSPITALIZATION CONDITION CODE 41 NOT APPROPRIATE FOR THIS TYPE OF BILL
AP048	RESUBMIT CORRECTION - RETURN TO PROVIDER REVENUE CODE REQUIRES HCPC OR CPT CODE
AP051	RESUBMIT CORRECTION - RETURN TO PROVIDER OVERLAPPING OBSERVATION PERIODS (NOT YET IMPLEMENTED)
AP052	RESUBMIT CORRECTION - RETURN TO PROVIDER OBSERVATION SERVICES NOT SEPARATELY PAYABLE
AP054	RESUBMIT CORRECTION - RETURN TO PROVIDER MULTIPLE CODES FOR THE SAME SERVICE
AP055	RESUBMIT CORRECTION - RETURN TO PROVIDER NOT REPORTABLE FOR THIS SITE OF SERVICE
AP056	RESUBMIT CORRECTION - RETURN TO PROVIDER OBSERVATION SERVICE E&M REQUIREMENTS NOT MET, SERVICE DATE N OT 12/31 OR 01/01

AP058	RESUBMIT CORRECTION - RETURN TO PROVIDER G0379 ONLY ALLOWED WITH G0378
AP059	RESUBMIT CORRECTION - RETURN TO PROVIDER CLINICAL TRIAL REQUIRES DIAGNOSIS CODE V707 AS OTHER THAN PR IMARY DIAGNOSIS
AP060	RESUBMIT CORRECTION - RETURN TO PROVIDER USER OF MODIFIER CA WITH MORE THAN ONE PROCEDURE NOT ALLOWED
AP061	RESUBMIT CORRECTION - RETURN TO PROVIDER CODE CAN ONLY BE BILLED TO THE DME REGIONAL CARRIER
AP062	RESUBMIT CORRECTION - RETURN TO PROVIDER CODE NOT ALLOWED UNDER OPPS, ALTERNATE MAY BE AVAILABLE
AP063	RESUBMIT CORRECTION - RETURN TO PROVIDER OCCUPATION THERAPY CAN ONLY BE BILLED ON PARTIAL HOSPITALIZA TION CLAIMS
AP065	RESUBMIT CORRECTION - ERROR DISPOSITION 01 - LINE REJECTION REVENUE CODE NOT RECONGNIZED BY MEDICARE
AP070	RESUBMIT CORRECTION - RETURN TO PROVIDER CA MODIFIER REQUIRES PATIENT STATUS 20
AP071	RESUBMIT CORRECTION - RETURN TO PROVIDER CLAIM LACKS REQUIRED DEVICE CODE
AP072	RESUBMIT CORRECTION - RETURN TO PROVIDER SERVICE NOT BILLABLE TO FISCAL INTERMEDIARY
AP073	RESUBMIT CORRECTION - RETURN TO PROVIDER INCORRECT BILLING OF BLOOD AND BLOOD PRODUCT
BILL	RESUBMIT CORRECTION - REQUEST ITEMIZED BILL AND MEDICAL RECORDS FOR REVIEW TO PROPERLY ADJUDICATE THE CLAIM
BPNPI	Resubmit Billing Provider NPI
BTYPE	RESUBMIT CORRECTION - THE BILLE TYPE DOES NOT MATCH BILLED SERVICES
CPTCD	RESUBMIT CORRECTION - CPT CODE IS INVALID OR MISSING
D02	Incomplete claim form.
D03	Submit appropriate claim form
D04	Requires additional information.
D05	Requires anesthesia time.
D06	Resubmit claim with Medicare EOB
D07	Resubmit with primary EOB
D101	Primary Diagnosis Required
D13	Incorrect authorization number.
D14	Requires prior authorization.
D44	Please resubmit claim with ER report.
D47	Resubmit with OP report.
D49	Please resubmit claim with physician notes.
D51	Please resubmit claim with a copy of the consult report.
D52	Resubmit with dialysis reports.
D54	Itemized statement required.
D58	Need ambulance EMS report.
D59	Requires discharge summary.
D64	Resubmit to dental plan.
DHCAHL	RESUBMIT WITH CMS CAH RATE LETTER FOR REASONABLE COST REIMBURSEMENT
DIAGN	RESUBMIT CORRECTION - ICD-9 DIAGNOSIS CODE MISSING OR INVALID FOR PT IN QUESTION
DOS	RESUBMIT CORRECTION - DATES OF SERVICE ON CLAIM APPEAR TO BE INCORRECT
GENDR	RESUBMIT CORRECTION - BILLED CPT CODE DOES NOT MATCH PATIENT'S SEX
HCPC	RESUBMIT CORRECTION - OUTDATED OR MISSING HCPC CODE CANNOT ADJUDICATE
ICDIND	RESUBMIT CORRECT ICD INDICATOR
INPOS	RESUBMIT CORRECTION - PLACE OF SERVICE DOES NOT MATCH BILL TYPE
INVAL	RESUBMIT CORRECTION - INVALIED CPT OR REV CODE OR HCPC CODES
INVBL	RESUBMIT CORRECTION - BILLED SERVICES DO NOT MATCH SERVICES AUTHORIZED
INVMO	RESUBMIT CORRECTION - INVALID MODIFIER FOR CPT CODE IN QUESTION
INVOI	INVOICE REQUIRED
M0010	No Active Provider Contract
M0014	No Contract Term found for Service
M0016	No Benefit for Service
M0018	Invalid Accommodation Days

M0025	Claim Total Mismatch
M0027	Primary ICD9 Diagnostic Code Required
M0028	Discharge Status Required for Inpatient and SNF Claims
M0054	Manually Pended Claim
M0072	Benefit Requires Manual Review
M0073	Contract Term Requires Manual Review
M0074	Provider on Pay Hold
MODIF	RESUBMIT CORRECTION - THE PROCODURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.
MRR	RESUBMIT CLAIM WITH MEDICAL RECORDS
NBSI	Resubmit claims under newborns State ID.
NCCOB	RESUBMIT CORRECTION-REQUIRE COB FROM PATIENT'S PRIMARY INSURANCE
NCDRG	RESUBMIT CORRECTION - RESUBMIT WITH INPATIENT DRG FOR PROPER ADJUDICATION MEDICARE VERSION 25 AND MEDICAID VERSION 24
NCREV	RESUBMIT CORRECTION - OUTDATED OR INCORRECT REV CODE OR MISSING REV CODE
NCSIT	RESUBMIT CORRECTION - MISSING OR INVALID CLINIC SITE ID
SUBID	RESUBMIT CORRECTION - CLAIM SUBMITTED WITH INCORRECT SUBSCRIBER ID RESUBMIT WITH CORRECTION
SVC	RESUBMIT CORRECTION - SERVICES DO NOT MATCH PROVIDER SPECIALTY TYPE
W-9	RESUBMIT CORRECTION - REQUEST W9 WITH TIN# AND NPI # FOR PROVIDER AND VENDOR
NOT COVERED REASONS	
001	Services are Inclusive
59	Benefit Restriction Message
220	{}default message{}
524	CPT codes billed include bundled and unbundled CPTs
991	Claim denied. Requested information not received within 35 days.
120DY	120 DAYS TIMELY FILING
20VST	PT HAS REACHED 20 VISIT BENEFIT MAXIMUM FOR MENTAL HEALTH VISITS
240DY	240 DAYS TIMELY FILING
24MO	BENEFIT USED WITHIN LAST 24 MONTH PERIOD
45DY	APPEAL DENIED CLAIM RECEIVED AFTER 45 DAY LIMITS
59a	Plan Restriction Message
A0100	Prior authorization is awaiting medical review.
A0101	Authorization Amount overrides Contract Amount
A0624	Authorization Line Manually Denied
A0625	Authorization Line Manually Pended
A0626	Authorization Status Manually Set
AAREV1	Remit Non PCP claim with PCP change
AAREV10	REMIT Qualifying claim not finalized – reversed determining claim
AAREV11	REMIT finalized qualifying claim – reversed determining claim
AAREV12	REMIT Claim with Enrollment Status Change
AAREV13	REMIT Claim with External Enrollment Coverage Type Change
AAREV14	REMIT LOI Records Added or Changed
AAREV15	REMIT E/R Claim reversed due to receipt of inpatient claim.
AAREV16	This history claim was adjusted to pay/deny as recommended by ClaimCheck
AAREV17	REMIT Claim was opened or adjusted based on request by NxPBA
AAREV18	REMIT Claim was reversed or voided by Post Connect Adjust
AAREV19	Non Clean Claim
AAREV2	Remit PCP claim with PCP change
AAREV3	REMIT retro term enrollment

AAREV4	REMIT denied claim with valid enrollment
AAREV5	REMIT retro auth change
AAREV6	REMIT contract change
AAREV7	REMIT contract term change
AAREV9	REMIT retro termed Pre-X
ADADJ	THIS IS AN ADJUSTMENT TO A PREVIOUS CLAIM
ADHCOR	ADJUSTED PER PROVIDER REQUEST (Cancellation/Void)
ADHMS	COB MEMBER HAS PRIMARY COVERAGE
ADJOV	OVERAGE PROJECT ADJUSTMENT
ADPRM	TAKEBACK OTHER CARRIER PRIMARY
ALMAN	NO RATE AVAILABLE/MANUAL PRICE
ALMCD	PAYMENT BASED ON MEDICAID FEE SCHEDULE
ALPRV	PROVIDER INELIGIBLE ON DATE OF SERVICE
ANMOD	INVALID PRIMARY ANESTHESIA MODIFIER
AP004	ERROR DISPOSITION 03 - SUSPENSION MEDICARE AS SECONDARY PAYER ALERT
AP009	ERROR DISPOSITION 02 - LINE DENIAL NON-COVERED SERVICE
AP010	ERROR DISPOSITION 06 - CLAIM DENIAL NON-COVERED SERVICE SUBMITTED FOR VERIFICATION OF DENIAL (CO NDITION CODE 21)
AP011	ERROR DISPOSITION 03 - SUSPENSION NON-COVERED SERVICE SUBMITTED FOR REVIEW (CONDITION CODE 20)
AP012	ERROR DISPOSITION 03 - SUSPENSION RETURN TO PROVIDER QUESTIONABLE COVERED SERVICE
AP013	ERROR DISPOSITION 01 - LINE REJECTION ADDITIONAL PAYMENT FOR SERVICES NOT PROVIDED BY MEDICARE
AP019	ERROR DISPOSITION 01 - LINE REJECTION MUTUALLY EXCLUSIVE PROCEDURE NOT ALLOWED
AP020	ERROR DISPOSITION 01 - LINE REJECTION COMPONENT OF COMPREHENSIVE PROCEDURE NOT ALLOWED
AP028	ERROR DISPOSITION 01 - LINE REJECTION CODE NOT RECOGNIZED BY MEDICARE; ALTERNATE CODE FOR SAME SER VICE MAY BE AVAILABLE
AP031	ERROR DISPOSITION 03 - SUSPENSION PARTIAL HOSPITALIZATION ON SAME DAY AS ELECTOCONVULSIVE THER APY (ECT) OR SIGNIFICANT PROCEDURE (TYPE T)
AP032	ERROR DISPOSITION 03 - SUSPENSION PARTIAL HOSPITALIZATION WHICH SPANS THREE OR LESS DAYS AND H AS INSUFFICIENT SERVICES OR HAS SIGNIFICANT PROCEDURE (TYPE T) ON AT LEAST ONE OF THE DAYS
AP033	ERROR DISPOSITION 03 - SUSPENSION PARTIAL HOSPITALIZATION CLAIM SPANS MORE THAN THREE DAYS, IN SUFFICIENT DAYS WITH MENTAL HEALTH SERVICES
AP034	ERROR DISPOSITION 03 - SUSPENSION PARTIAL HOSPITALIZATION CLAIM SPANS MORE THAN THREE DAYS WIT H INSUFFICIENT NUMBER OF DAYS MEETING PARTIAL HOSPITALIZATION CRITERIA
AP036	ERROR DISPOSITION 03 - SUSPENSION EXTENSIVE MENTAL HEALTH SERVICES ON DAY OF ELECTROCONVULSIVE THERAPY OR SIGNIFICANT PROCEDURE
AP045	ERROR DISPOSITION 01 - LINE REJECTION
AP047	ERROR DISPOSITION 01 - LINE REJECTION SERVICE IS NOT SEPARATELY PAYABLE
AP049	ERROR DISPOSITION 02 - LINE DENIAL SERVICE IS ON SAME DATE AS INPATIENT PROCEDURE
AP050	ERROR DISPOSITION 01 - LINE REJECTION NON-COVERED BY STATUTORY EXCLUSION
AP053	ERROR DISPOSITION 01 - LINE REJECTION OBSERVATION SERVICE CODE ONLY ALLOWED WITH BILL TYPE 13X
AP057	ERROR DISPOSITION 03 - CLAIM SUSPENSION OBSERVATION SERVICE E&M REQUIREMENTS NOT MET, SERVICE DATE 01/01
AP064	ERROR DISPOSITION 01 - LINE REJECTION ACTIVITY THERAPY NOT PAYABLE OUTSIDE THE PARTIAL HOSPITALIZA TION PROGRAM
AP066	ERROR DISPOSITION 03 - CLAIM SUSPENSION CODE REQUIRES MANUAL PRICING
AP067	ERROR DISPOSITION 01 - LINE REJECTION SERVICE PROVIDED PRIOR TO FDA APPROVAL
AP068	ERROR DISPOSITION 01 - LINE REJECTION SERVICE PROVIDED PRIOR TO DATE OF NATIONAL COVERAGE DETERMIN ATION
AP069	ERROR DISPOSITION 01 - LINE REJECTION SERVICE PROVIDED OUTSIDE LIMITED APPROVAL PERIOD
AP074	UNITS > ONE FOR BILATERAL PROC BILLED W/MODIFIER 50
AUREQ	AUTHORIZATION IS REQUIRED FOR SERVICES
AUTHD	AUTHORIZATION DENIED
AUTHNM	PROCEDURES / SERVICES AUTHORIZED DO NOT MATCH CLAIM
AUVIS	AUTHORIZATION VISITS EXCEEDED
BHO	SERVICES NOT COVERED UNDER MEDICAL PLAN BILL BHO

BILLC	REFUND DUE TO BILLING CORRECTION FROM PROVIDER
BILLE	PROVIDER BILLING ERROR
BUND	Bundled Service
CHIRO	ALL CHIRO CLAIMS NEED TO BE SUBMITTED THROUGH COLUMBINE CHIROPRACTICE SERVICES
CM302	Only one family planning visit allowed per date of service.
COFIN	SUBMIT CLAIMS THROUGH COFINITY EDI PAYER #38335.
CON510	Per contract clinic visit billed with a revenue code 510 code is not payable. Member not liable
CONTR	Paid at contracted rate
CRATE	COFINITY NEGOTATED CASE RATE INCLUDES WELL BABY DISCHARGED W/MOM
D0001	SERVICE RESPONSIBILITY OF LAB CORP ONLY
D001	New Member Letter
D01	Requires manual processing.
D08	Billed amount exceeds UCR.
D080	Co-Surgeon Not Covered
D081	Team Surgeon Not Covered
D10	Medical review denial.
D11	Triage only - not life threatening.
D12	Requires authorized referral.
D15	Member not enrolled on DOS.
D15A	Member was not enrolled with this Medical Group on DOS .
D16	Patient not enrolled with Plan.
D17	Service not a plan benefit.
D18	Included in other procedure.
D19	Limited service exceeded.
D20	Assistant surgeon not covered.
D21	Incorrect Plan ID code.
D22	Incorrect AHCCCS ID code.
D23	Unauthorized provider.
D24	Duplicate Claim (Provider/Member/DOS)
D25	Claim submit time exceeded.
D26	Procedure code not on file.
D27	Diagnosis code not on file.
D28	Member ID number invalid.
D29	Category of service invalid.
D30	Stat charges are not covered.
D31	Service a part of lab contract.
D32	Service a part of Rx contract.
D33	Included in capitation.
D34	Submitted to plan in error.
D37	Services exceed Psych benefit.
D39	Plan not notified in time.
D40	Member responsible for charges.
D41	W/O contractual agreement.
D42	Reduce to urgent care.
D43	No stat order.
D45	Adjust to authorized level of care.
D46	No response to COB inquiry.

D48	Requires H&P.
D50	Included in OB package.
D53	Split billing required.
D55	Authorization number invalid for DOS.
D56	Revenue code missing / invalid.
D57	DOS incorrect.
D60	Claim has been denied. At DOS, assigned to other PCP.
D6000	The Provider is not a member of the UHC PPO Network.
D61	DME rental costs have exceeded purchase price.
D62	Patient not enrolled with plan.
D63	CPT code terminated.
D65	Denied: Workmens Compensation.
D66	N/C. Routine well baby.
D67	Non-emergent services. Medical review denial.
D68	Plan not advised in 72 hrs. Medical review denial.
D69	Claim Doesn't have any Service Lines
D70	Electronic Claim has COB
D71	Duplicate Line on Same Claim
D72	Prior authorization is closed.
D73	Prior authorization services do not match claim.
D74	Prior authorization is denied.
D75	Prior authorization cost estimate exceeded.
D76	Prior authorization not for same member.
D77	Prior authorization is not for same provider.
D77A	Provider's specialty does not match authorized specialty
D77B	Provider's group does not match authorized group
D77C	Provider's network does not match authorized network
D77D	Provider's participation status does not match authorized
D77E	Provider type does not match authorized provider type
D77F	Place of service does not match authorized
D78	Prior authorization is pended.
D79	Prior authorization not found.
D80	Prior authorization has no units available.
D81	Prior authorization has insufficient units remaining
D82	CPT codes billed include bundled and unbundled
D83	Invalid ICD9 Procedure Code
D84	Invalid ICD-9 Diagnosis Code
D85	Diagnosis not valid for Benefit
D86	Team Surgeon not covered
D87	Co-Surgeon not Covered
D88	Claim line exceeds available bed days on auth.
D89	Authorization line item denied.
DELIV	MEDICAID REQUIREMENTS IF MOM & BABY ARE DISCHARGED SAME DAY CHARGES MUST BE COMBINED.
DELTA	BILL TO DELTA DENTAL
DENY	NOT COVERED
DH450	Emergency services paid on new additional claim.
DH541	TIMELY FILING

DHA001	ADJUSTMENT FOR CONTRACT FEE SCHEDULE CORRECTION
DHABMS	ERROR ADJUSTMENT
DHACC	CORRECTED CLAIM ADJUSTMENT
DHADJ	This is an adjustment to previous claim.
DHAINPRV	INCORRECT PROVIDER
DHAOOP	OUT OF POCKET ADJUSTMENT
DHAPR	This claim is considered part of global contract agreement. No additional payment will be made
DHAVOID	CHECK VOIDED INCORRECT PROVIDER
DHC001	NO FACTOR IN THE FEE SCHEDULE.
DHCAD	CLAIM LINE OVERLAPS CONTRACT AFFILIATION TERM DATE
DHCAH	PAID PER CMS CAH RATE LETTER
DHCAP	Capped rental period reached. No further rental payments may be made.
DHCCR	Medicaid cost-to-charge allowable
DHCFT	INVALID CLAIM FORM TYPE
DHCHP	Paid per % CHP Plus fee schedule
DHCON	INVALID CONDITION CODE ON DOS
DHCOR	ADJUSTED PER PROVIDER REQUEST
DHCTD	CLAIM LINE OVERLAPS CONTRACT TERM TERMINATION DATE.
DHDIG	DIAGNOSIS POINTER REQUIRED ON SERVICE LINE FOR DIAGNOSIS CODES
DHEAPG	EAPG PRICING APPLIED
DHERS	INPATIENT CLAIM / UM EXISTS FOR SAME DOS AS ER CLAIM
DHESRD	Included in dialysis composite rate.
DHFTD	CLAIM LINE OVERLAPS FEE TABLE VALUE TERMINATION DATE.
DHICD	Rebill with correct ICD-10 Code
DHITM	REQUIRE ITEMIZED BILL
DHM51	MULTIPLE SURGERIES - CLAIM SUBMITTED MISSING MODIFIER 51
DHMCRCOB	INVALID MEDICARE COB AMOUNT
DHMOD	INVALID MODIFIER CODE ON DOS
DHNDC	Invalid/Missing NDC Code
DHNDC2	Invalid NDC and J Code Combination.
DHNEW	New born not covered under the Med Adv Program
DHOCC	INVALID OCCURRENCE CODE ON DOS
DHOCS	INVALID OCCURRENCE SPAN CODE
DHPOA	INVALID POA INDICATOR ON DIAGNOSIS CODE.
DHPOA2	DIAGNOSIS CODE REQUIRES POA INDICATOR
DHPOS	INVALID PLACE OF SERVICE CODE
DHSPLT	Claim must be split with ICD-9 codes prior to 10/1/15 and ICD-10 codes for 10/1/15 and later
DHTWT	HT AND WT REQD TO CALC DIALYSIS PAYMENT
DHVAL	INVALID VALUE CODE ON DOS
DHVFC	VACCINE IS SUPPLIED THROUGH THE VFC PROGRAM
DHWIN	CLAIM LINE SUBMISSION WINDOW OVERLAP
DIAL	Occurrence Code of Date of last Kt/V reading missing
DKTV	AUTH DENIED - BENEFIT EXCEEDED
DNADB	HEMATOCRIT VALUE REQD
DNMCA	PRIMARY INSURANCE ALLOWED > MEDICAID ALLOWABLE - IT IS A CONTRACTUAL ADJUSTMENT.
DNPRI	PRIMARY PMT IS GREATER THAN ALLOWABLE CHARGE BALANCE IS A CONTRACTUAL ADJUSTMENT.
DUPOC	Duplicate of an original claim already in process

DUPPD	DUPLICATE OF A PREVIOUSLY PAID CLAIM
DV49	VALUE CODE A8 OVER 500KG DIALYSIS
EQUIP	EQUIPMENT INCLUDED WITH RENTAL/PURCHASE
ESRD	Payment based on 2014 ESRD Pricer.
EXCED	SERVICES EXCEEDED PLAN BENEFIT LIMIT
EXCL	THESE SERVICES ARE NOT COVERED UNDER THE PLAN
EXCOTR	Coverage terminated for non-payment of Premium
EXCVI	SERVICES EXCEEDED PLAN VISIT LIMIT
EXHT	REQ MED RECS FOR DIALYSIS QTY
EXMB	THESE SERVICES ARE NOT COVERED UNDER THE PLAN. MEMBER MAY BE LIABLE.
EXMR	DIALYSIS CLM OVER QTY FOR REV CODE 634
EXNC	THESE SERVICES ARE NOT COVERED UNDER THE PLAN FOR OUT OF NETWORK.
EXUV	VALUE CODE A9 OVER 300CM DIALYSIS
FM178	COLORADO MEDICAL ASSISTANCE PROGRAM STERILIZATION CONSENT FORM MED 178 IS REQUIRED IN ORDER TO PROPERLY ADJUDICATE THE CLAIM.
FWA	FRAUD WASTE AND ABUSE
GLOB1	Service included in payment for surgical procedure.
GLOBL	THIS SERVICE IS COVERED UNDER GLOBAL PERIOD
GRACE	GRACE DAY
H1	Credit applied for prior RAP payment
H2	Therapy Threshold not met
INGLO	SERVICES INCLUDED WITH NEGOTIATED OR GLOBAL RATE
LIFET	SERVICES EXCEEDED PLAN LIFETIME MAX
M0011	Provider Not Active for Plan on DOS
M0012	Invalid Approved Provider Service for Provider
M0015	Referral Required by Contract
M0017	Incorrect age for Nursery charges
M0019	Benefit Requires Prior Authorization
M0020	Benefit Visit Limit Exceeded
M0021	Benefit Dollar Limit Exceeded
M0022	Benefit Applies to PCP Only
M0023	Admit Date Required for Inpatient Claim
M0024	Attending Physician Required for Inpatient Claims
M0026	Invalid Bill Type
M0029	Interim Claim with no Initial Claim
M0030	Duplicate Claim Line(Member/DOS/CPT(Rev))
M0031	Invalid CPT Modifier
M0032	Invalid CPT/HCPCS
M0033	Invalid Revenue Code
M0034	Modifier required for CPT/HCPCS
M0035	Revenue Code Requires HCPCS
M0036	Physicians Assistant requires Modifier 80 or 27
M0037	CRNA requires Modifier AA
M0038	Invalid Line Date of Service
M0039	Invalid Start Date
M0040	Invalid End Date
M0041	Invalid Discharge Status
M0042	Invalid Revenue Code for Bill Type

M0043	Invalid HCPCS for Revenue Code
M0044	Claim Tiers Do Not Match Referral
M0045	Missing Primary Diagnosis
M0046	Admit Type Required
M0047	Discharge Status Required
M0048	Invalid For Male
M0049	Invalid For Female
M0050	No Enrollment
M0051	Duplicate Claim (Member/DOS)
M0052	Coverage Period Insufficient for Benefit Coverage
M0053	Member has no active enrollment on DOS
M0055	Provider is not part of Network required for Benefit
M0056	Service is capitated to PCP or IPA
M0057	No Attending Physician ID (Outpatient)
M0058	Provider is Not Credentialed
M0059	Claim amount exceeds maximum allowed during Mass Adjudication
M0060	Negative charge on claim line
M0061	Provider has Alert/Memos
M0062	Provider Watch flag has been set for review
M0063	Claim amount exceeds Maximum allowed
M0064	Provider does not match required type
M0065	Provider requires a specialty code
M0066	Claim denied manually
M0067	Electronic claim has COB
M0068	Benefit has age restrictions
M0069	Provider type does not match term
M0070	PCP is solely responsible for services
M0071	Price UB by CPT billed yes/no
M0075	Invalid Admit Hour
M0075a	Annual Benefit Amount Exceeded
M0076	Invalid Discharge Hour
M0077	Claim Doesn't have any Service Lines
M0078	Generate 1500 From EPSDT Form
M0080	Claim payment amt exceeds max allowed for mass adjudication
M0087	Claim payment amount exceeds maximum allowed
M0088	Claim payment amt exceeds max allowed for mass adjudication
M0089	EARLY INTERVENTION SERVICES (EIS) ARE DENIED, PROVIDERS MUST BILL FOR EIS THRU THE EIS TRUST FUND
M0090	MEMBER IS DECEASED PRIOR TO DATE OF SERVICE ON CLAIM
M0091	Provider not revalidated per Colorado Medicaid
M1	The hospital has by contract agreed to accept as payment in
M10	Services are not eligible with diagnosis provided by physici
M11	Service is not related to direct treatment of an illness or
M12	Service appears to be experimental and is not covered by the
M14	If you have any questions concerning this claim, please call
M16	The payment amount has been reduced by the amount paid by th
M2	The amount shown as eligible is the maximum amount allowable
M3	This is a duplicate of a claim that has been previously proc

M345	Out-of-Area Claim - Pay at 80%
M389	Non-Participating Differential Contract Pricing Applied
M4	Benefits for the above charges are subject to a reduction be
M5	Payment has been made at 85% of the eligible amount. The am
M6	Payment has been made at 100% of the eligible amount. The a
M7	Well child care is not eligible under the plan.
M8	Annual/routine physicals, or routine lab or x-rays are not e
M9	Routine eye exams are not eligible under the plan.
MAX20	$2000 MAXIMUM BENEFIT EXCEEDED
MBRIN	MEMBER INELIGIBLE ON DATE OF SERVICE
MCMAX	MEMBER HAS MET THEIR MEDICARE LIFETIME MAX BENEFIT
MCRHOS	The member has elected Hospice. Please submit claims to Medicare for Payment
MP001	When multiple procedures are performed on the same day, payment is made based on the highest amount allowed.
MP005	Payment for this procedure is included with the payment made for medical treatment rendered on the same day by a different provider.
MP006	Payment for prenatal and postnatal care is included in the payment for the obstetrical procedure. No additional payment can be made.
MP007	If prenatal care and OB procedure is on paid history within 270 days, same provider, related or unrelated diag, claim is rejected.
MP009	If postnatal and an OB proc. are on same claim or paid history, and postnatal care is within 45 days of post ob proc., same prov, related or unrelated diag, claim is denied.
MP010	Payment for this procedure is included with the payment made for the surgical procedure.
MP011	Payment for this consultation is included in the payment for anesthesia. No separate payment can be made.
MP012	A payment cannot be made for more than three physical therapy procedures.
MP013	If major surgery is performed same day as major/minor surgery, same POS, already paid on history and prov are same or different. Claim is pended
MP014	If assistant surgery is performed on the same day as another asst surgery, on the same claim or paid history, same POS and the prov are different. Pend claim.
MP015	If anesthesia is performed on the same day, same POS as anesthesia no the same claim and the prov are the same or different, pay 100% of time and base unit allowance for greater procedure and 100% of time for each lesser procedure. Pend claim.
MP016	Medical necessity not established for services rendered.
MXMTH	MAX VISITS DIALYSIS PER MONTH EXCEEDED
MXPWK	MAX DIALYSIS VISITS PER WEEK EXCEEDED
N390	This service cannot be billed separately.
N775	Payment adjusted based on x-ray radiograph on film
NCACS	AUTHORIZATION CLOSED
NCARQ	AUTHORIZATION REQUIRED
NCBMC	NOT COVERED BY MEDICARE
NCBMD	NOT COVERED BY MEDICAID
NCCOB	EOB FROM PRIMARY CARRIER NEEDED TO ADJUDICATE CLAIM
NCLTK	SUBMIT CLAIMS TO LIFE TRAC FOR RE-PRICING
NCOPT	SUBMIT CLAIM TO OPTUM HEALTH CARE
NCPCA	Not covered per contracted agreement
NCWRP	WRAPAROUND BENEFIT - BILL MEDICAID FEE FOR SERVICE
NELIG	MEMBER NOT ELIGIBLE ON DATE OF SERVICE
NOAUT	SERVICES WERE NOT AUTHORIZED
NOCLM	DENVER HEALTH MEDICAL PLAN DOES NOT PROCESS CLAIMS FOR THIS LINE OF BUSINESS - CLAIM DENIED
NOFAC	NO FACTOR IN RBRVS CANNOT CALCULATE PRICE
OCE001	Invalid diagnosis code.
OCE002	Invalid diagnosis based on patient age
OCE003	Invalid diagnosis based on patient sex
OCE005	E- Diagnosis code can not be used as principal.

OCE006	Invalid procedure code.
OCE007	Invalid procedure based on patient age.
OCE008	Invalid procedure based on patient sex
OCE009	Non-covered for reason other than statute
OCE010	Services submitted for FI review condition code 21
OCE013	Separate payment for service is not provided by the plan.
OCE014	Code indicates a site of services not included in OPPS
OCE015	Invalid/incomplete/incorrect units
OCE016	Multiple bilateral procedures without modifier 50
OCE017	Inappropriate specification of bilateral procedure
OCE018	Inpatient procedure.
OCE019	Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present.
OCE020	Code 2 of a code pair that is not allowed by NCCI even if appropriate modifier is present.
OCE021	Medical visit on same day as type T or S procedure without modifier 25.
OCE022	Invalid modifier
OCE023	Invalid date
OCE024	Date out of OCE range
OCE025	Invalid age
OCE026	Invalid sex
OCE027	Only incidental services reported.
OCE028	Code not recognized by Medicare; Alternate code for same service may be available.
OCE029	Partial hospitalization services for non-mental health diagnosis.
OCE030	Insufficient services on day of partial hospitalization
OCE035	Only Mental Health education and training services provided
OCE036	Terminated bilateral procedure or terminated procedure with units greater than one.
OCE038	Inconsistency between implanted device or administered substance and implantation or associated procedure.
OCE039	Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present.
OCE040	Code 2 of a code pair that would be allowed by NCCI if appropriate modifier were present.
OCE041	Invalid Revenue Code
OCE042	Multiple medical visits on same day with same revenue code without condition code G0
OCE043	Transfusion or blood product exchange without specification of blood product.
OCE044	Observation revenue code on line item with non-observation HCPCS code
OCE045	Inpatient separate procedures not paid.
OCE046	Partial hospitalization condition code 41 not approved for type of bill.
OCE047	Service is not separately payable.
OCE048	Revenue center requires HCPCS
OCE049	Service on same day as inpatient procedure.
OCE050	Non-covered based on statutory exclusion.
OCE051	Multiple observations overlap in time.
OCE052	Observation does not meet minimum hours, qualifying diagnoses, and or T procedure conditions
OCE053	Codes G0378 and G0379 only allowed with Bill Type 13x
OCE054	Multiple codes for the same services.
OCE055	Non-reportable for site of services
OCE056	EM condition not met and line item date for OBS code G0244 is not 12-31 or 01-01.
OCE057	EM Condition not met for separately payable observation and line item date for code G0378 is 01-01
OCE058	G0379 only allowed with G0378
OCE059	Clinical trial requires diagnosis code V707 as other than primary diagnosis.

OCE060	Use of modifier CA with more than one procedure not allowed
OCE062	Code not recognized by OPPS; alternate code for same service may be available
OCE063	This code only billed on partial hospitalization claims
OCE064	AT service not payable outside the partial hospitalization.
OCE065	Revenue code not recognized by Medicare
OCE067	Service provided prior to FDA approval
OCE068	Service provided prior to date of National Coverage Determination (NCD) approval
OCE069	Service provided outside approval period
OCE070	CA modifier requires patient status code 20
OCE071	Claim lacks required device or procedure code
OCE072	Service not billable to Fiscal Intermediary
OCE073	Incorrect billing of blood products
OCE074	Units greater than one for bilateral procedure billed with modifier 50
OCE076	Trauma response critical care code without revenue code 068x and CPT 99291
OCE077	Claim lacks allowed procedure code
OCE078	Claim lacks required radiolabeled product
OCE079	Incorrect billing of revenue code with HCPCS code
OCE080	Mental health code not approved for partial hospitalization program
OCE081	Mental health service not payable outside the partial hospitalization program
OCE082	Charge exceeds token charge ($1.01
OCE083	Service provided on or after effective date of NCD non-coverage
OCE084	Claim lacks required primary code
OCE085	Claim lacks required device or procedure code
OCE100	One or more lines on the claim has returned an OCE error with a Return to Provider disposition
OCE101	Modifier PN is reported for an item or service that is considered to be non-excepted for an off-campus provider-based hospital outpatient department under Section 603
OCE86	Manifestation code not allowed as principal diagnosis
OCE87	Skin substitute application procedure without appropriate skin substitute product code
OCE88	FQHC payment code not reported for FQHC claim
OCE89	FQHC claim lacks required qualifying visit code
OCE90	Incorrect revenue code reported for FQHC payment code
OCE91	Item or service not covered under FQHC PPS
OCE92	Device-dependent procedure reported without device code
OFFIC	OFFICE VISIT IS NOT PAYABLE SAME DAY AS SURGERY
OOA	OUT OF NETWORK
P01	Member Not On File
P02	Provider Not on File
P03	No Enrollment
P123	Possible TLP claim/auth
PACK	Packaged service/item; no separate payment made
PDLMT	PODIATRY LIMIT OF 1 VISIT PER 60 DAYS MET
PENPD	PENALTY AMOUNT PAID
POS	CPT CODE DOES NOT MATCH POS
PURCH	THIS IS A PURCHASE ONLY ITEM
R0008	Claim requires manual processing
R001	No Contract with Provider
R002	No Provider Affiliation with Health Plan

R003	Service Not Covered by Contract with Provider
R004	Not eligible for service under plan
R005	Age Incorrect for Nursery Charges
R0208	Provider doesn't meet criteria required to provide service
R07	Invalid Co-Insurance Days for 11x Bill Type
R101	Prior authorization not for same member
R173	Diagnosis Code on Claim does not Match Term
R180	No Employer Fee For Service
R203	Service is excluded from benefit plan.
R219	Provider overlaps global days period
R301	No COB entered with a secondary enrollment
R302	Member has an active restriction on enrollment
R303	Assistant surgeon not allowed
R304	Co-surgeon not allowed
R305	Team surgeon not allowed
R306	Covered days do not match accomodation revcode days
R307	Non-covered days less than leave of absence
R308	Invalid lifetime reserve days
R309	Admit type does not match admit source
R311	Invalid coinsurance days for 21x bill type
R312	Coinsurance days exceeds covered days
R313	Coinsurance days missing associated value codes
R314	Covered days and coinsured days exceed maximum for hospital
R315	Covered days exceeds maximum for hospital
R316	Covered days and coinsured days exceed maximum for SNF
R317	Covered days exceed maximum for SNF
R318	Non-covered days exceed statement-covered period
R319	Life reserve days exceed maximum
R320	Admit type requires 450 revcode
R321	Admission source required
R322	Invalid patient status for bill type
R323	Surgical procedure requires HCPCS
R324	Admit type required for 11x bill type
R325	Invalid ICD-9 procedure code
R530	Insufficient Units For Date Span
REFUN	THIS ADJUSTMENT IS FOR A REFUND CHECK
RERA	RHC ENCOUNTER RATE ALLOWED
RHQ01178	Re-Processed Claim from Denial
RPINF	RESUBMIT RENDERING PROVIDER INFORMATION
RPLMT	ROUTINE PODIATRY LIMIT OF 4 PER YEAR MET
RPNPI	Resubmit Rendering Provider NPI
RPTI	Resubmit with Provider Pay to Information
S12	SNF benefit valid within 14 days of inpatient hospital stay
SAINP	SELF-AUDIT INTEREST/PENALTY CORRECTION
SAINT	SELF-AUDIT INTEREST CORRECTION
SUBRO	TAKEBACK DUE TO PRIMARY INSURANCE PAYMENT OR SUBRO
TIMEF	TIMELY FILING

UNL	Unlisted procedure codes not covered
VISLM	VISION LIMIT HAS BEEN MET
VMO01	This Line of Business is no longer covered by the Denver Health Medical Plan. Submit by Fax to 303-436-7381
VOID	CHECK VOIDED INCORRECT PROVIDER
WHSEQ	2% REDUCTION IN FEE DUE TO 04/01/2013 SEQUESTRATION
COPAY/COINSURANCE REASON CODES	
CPMAX	OUT OF POCKET MAXIMUM HAS BEEN REACHED
M13	A $10.00 co-pay has been taken. A $10.00 cost share has bee
DEDUCTIBLE REASON CODES	
AAREV8	REMIT deductibles
OTHER CARRIER REASONS	
D09	Paid by other insurance.
OCMCR	MEDICARE PRIMARY PAYMENT
OCPRM	PRIMARY PAYMENT BY OTHER CARRIER
R310	Other agency may be responsible for payment