reasonid reporttext

220 {default message}
524 CPT codes billed include bundled and unbundled CPTs
59 Benefit Restriction Message
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
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
AAREV8 REMIT deductibles
AAREV9 REMIT retro termed Pre-X
CM302 Only one family planning visit allowed per date of service.
CSSB_SC Sliding Copay Applied.
D001 New Member Letter
D01 Requires manual processing.
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.
D08 Billed amount exceeds UCR.
D080 Co-Surgeon Not Covered
D081 Team Surgeon Not Covered
D09 Paid by other insurance.
D10 Medical review denial.
D101 Primary Diagnosis Required
D11 Triage only - not life threatening.
D12 Requires authorized referral.
Incorrect authorization number.
Service Requires Authorization
Member Not Enrolled on Date Of Service.
Member was not enrolled with this Medical Group on DOS.
Patient not enrolled with Plan.
Service not a plan benefit.
Included in other procedure.
Limited service exceeded.
Assistant surgeon not covered.
Incorrect Plan ID code.
Incorrect AHCCCS ID code.
Unauthorized provider.
Duplicate Claim (Provider/Member/DOS)
Claim submit time exceeded.
Procedure code not on file.
Diagnosis code not on file.
Member ID number invalid.
Category of service invalid.
Stat charges are not covered.
Service a part of lab contract.
Service a part of Rx contract.
Included in capitation.
Submitted to plan in error.
Services exceed Psych benefit.
Plan not notified in time.
Member responsible for charges.
W/O contractual agreement.
Reduce to urgent care.
No stat order.
Please resubmit claim with ER report.
Adjust to authorized level of care.
No response to COB inquiry.
Resubmit with OP report.
Requires H&P.
Please resubmit claim with physician notes.
Included in OB package.
Please resubmit claim with a copy of the consult report.
Resubmit with dialysis reports.
Split billing required.
Itemized statement required.
Authorization number invalid for DOS.
Revenue code missing / invalid.
DOS incorrect.
Need ambulance EMS report.
Requires discharge summary.
Claim has been denied. At DOS, assigned to other PCP.
DME rental costs have exceeded purchase price.
D62 Patient not enrolled with plan.
D63 CPT code terminated.
D64 Resubmit to dental plan.
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 Benefit Requires Speciality Code not found on Provider
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 Dollar Limit 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 Required Prior Authorization Not On File
D80 Prior Auth is Closed
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.
GLOB1 Service included in payment for surgical procedure.
H1 Credit applied for prior RAP payment
H2 Therapy Threshold not met
i019 This is a duplicate claim, the original claim is being adjusted.
i020 Requested information not received from provider.
i021 A description of the drug is required
i022 Self-Administered drugs are non-covered.
i023 Required documentation is missing/invalid/incomplete.
i024 NDC Code does not match authorized
i025 Lifetime Benefit Amount Exceeded
i026 Family Lifetime Benefit Amount Exceeded
i027 Individual Lifetime Visits Exceeded
i028 Family Lifetime Visits Exceeded
i029  Plan Lifetime Amount Exceeded
i030  Plan Family Lifetime Max Exceeded
i031  Skilled nursing not covered
i032  Benefit Day Limit Exceeded
i033  Diagnosis code invalid for benefit
i034  Claim submission period exceeded
i035  Member not enrolled on end date DOS.
i036  Invalid or missing admission date
i037  Base fee not found or equals $0.00
i038  CPT Code is Bundled with Other CPT
i039  Multiple Instances of Revenue Code 0024
i040  Invalid Bill Type found on an IRF claim
i041  Multiple or invalid HIPPS codes found on IRF claim
i042  Invalid Place of Service Code
i043  COB claim exceeds submission window
i044  Prior auth exists for ER DOS and not the inpatient claim
i045  Invalid NDC Code
i046  Provider Contract And Claim Modifier Does Not Match.
i047  Claim and contract term type of service do not match
i048  Procedure code on claim does not match terms valid procedure
i049  Bill type on claim does not match contract term
i050  Emergency requirements on claim do not match contract term
i051  Location specific term does not match claim
i052  Maximum Per Day Dollar Limit Met
i053  Maternity services not covered
i054  Benefit requires valid modifier
i055  Service must be billed on a UB04 or Institutional format.
i056  Item or Service expected to be denied as not reasonable and necessary
i057  Service not valid with this Place of Service.
i058  Services are not covered.
i059  Claim does not meet Medicare guidelines for Inpatient Part B benefits.
i060  Invalid Modifier for Date Of Service.
i061  Invalid UB Occurrence Code on DOS.
i062  Invalid UB Occurrence Span Code on DOS.
i063  Invalid UB condition on DOS.
i064  APC-Packaged Service.
i065  Invalid UB Value on DOS.
i066  Resubmit claim with valid rendering provider.
i067  Non-Covered-Not a valid Medicare code.
i068  Claim denied as patient cannot be identified as our insured
i069  Corrected Claim
i070  Corrected claim, services not rendered
i071  Missing/incomplete/invalid taxonomy.
i072  Invalid DRG Submitted
i073  Valid revenue code required for Skilled Nursing claim submissions
i074  Self-administered drugs are not covered
i075  Adjusted - incorrect member/patient.
Processed according to the LTC contract or authorization.

Adjustment-Correction to Deductible/Co-pay

Adjustment-Correction to a previously processed claim

Deny – Medicare Statutory Excluded Services.

Home Health: "Processed according to LUPA/CMS guidelines"

ESRD: "Processed according to CMS/State ESRD guidelines"

Skilled Nursing: Processed according to CMS/State RUGs guidelines

IRF: Processed according to the CMS Inpatient Rehab Facility billing guidelines

Prior Authorization On File Is Not For The Same Provider

Prior Authorization On File Is Not For The Same Date Of Service

Drug Description Required And/OR Self Administered Drug Not Covered

Services Are Not A Covered Benefit When A Claim Is Submitted With This Bill Type.

Service(s) Are Not A Covered Benefit.

Stays of less than 24 hours are considered Outpatient

Provider Billing Error

This is a duplicate claim, the original claim is in process

Other Insurance Coverage Exists For Service Line Date.

Procedure Code Not Found Or Invalid For Date Of Service

Inpatient Days Exceeds Maximum For Covered Benefit.

Additional Payment Made on a Previously Processed Claim

Missing/Invalid/Incomplete TIN

Adjustment project – adjustment to a previously processed claim.

Adjustment includes coordination of secondary benefits.

This is a Measurement code for reporting purposes only.

Claims prior to 12/4/2011 are included in the settlement agreement and are not eligible for payment.

The date of service is outside of the contract benefits.

Adjustment to correct previously submitted diagnosis code.

This HIPPS RUGS service line should not have a dollar amount in the billed charges field.

Provider type does not match benefit requirement.

Payment amount reflects 2% Medicare Sequestration reduction.

Reimbursement for this service is based on ForwardHealth’s reimbursement reduction provision.

Critical Access Hospital (CAH) - Resubmit claim with CMS Rate Letter.

Claims with dates of service in 2011 are included in the settlement agreement and are not eligible for payment.

Claim adjusted based on DRG review.

EOB does not match current claim information being submitted

Missing/Incomplete information submitted on prior Insurance Carrier(s) EOB

Per ForwardHealth guidelines, claims for outpatient therapy services for Medicaid prime members must be billed on a professional HCFA form.

Follow Corrected Claim Submission Process

Member does not have iCare Medicaid coverage to process these Long Term Care services

Submit NEMT claims to MTM Inc, the DHS Transportation HMO and Manager.
i119  Please submit to WIDA
Per CMS, Ambulance transports of individuals with ESRD to and from renal dialysis
treatment are reduced by 10%.

i120  Adjusted, late charges submitted

i121  Adjusted, Void/Cancel of prior claim
Claims billed with the GY modifier are statutorily excluded or do not meet the definition of

i123  any Medicare benefit

M0010  No Active Provider Contract
M0011  Provider Not Active for Plan on DOS
M0012  Invalid Approved Provider Service for Provider
M0013  Provider Incomplete
M0014  No Contract Term found for Service
M0015  Referral Required by Contract
M0016  No Benefit for Service
M0017  Incorrect age for Nursery charges
M0018  Invalid Accomodation Days
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
M0025  Total Claim Dollars Do Not Match Total Line Item Dollars
M0026  Invalid Bill Type
M0027  Primary ICD9 Diagnostic Code Required
M0028  Discharge Status Required for Inpatient and SNF Claims
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 Of Service
M0040  Invalid End Date Of Service
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
M0054  Manually Pended Claim
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
M0072  Benefit Requires Manual Review
M0073  Contract Term Requires Manual Review
M0074  Provider on Pay Hold
M0075  Invalid Admit Hour
M0076  Invalid Discharge Hour
M0077  Claim Submitted Without 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
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
M7  Well child care is not eligible under the plan.
M9  Routine eye exams are not eligible under the plan.

When multiple procedures are performed on the same day, payment is made based on the
highest amount allowed.

Payment for this procedure is included with the payment made for medical treatment
rendered on the same day by a different provider.

Payment for prenatal and postnatal care is included in the payment for the obstetrical
procedure. No additional payment can be made.
If prenatal care and OB procedure is on paid history within 270 days, same provider, related or unrelated diag, claim is rejected.

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.

Payment for this procedure is included with the payment made for the surgical procedure. Payment for this consultation is included in the payment for anesthesia. No separate payment can be made.

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

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.

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.

Medical necessity not established for services rendered.
Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.

This reversal is due to a medical or utilization review decision.

Invalid diagnosis code.
Invalid diagnosis based on patient age.
Invalid diagnosis based on patient sex.
E- Diagnosis code can not be used as principal.
Invalid procedure code.
Invalid procedure based on patient age.
Invalid procedure based on patient sex.
Non-covered for reason other than statute.
Services submitted for FI review condition code 21.
Separate payment for service is not provided by the plan.
Code indicates a site of services not included in OPPS.
Invalid/incomplete/incorrect units.
Multiple bilateral procedures without modifier 50.
Inappropriate specification of bilateral procedure.
Inpatient procedure.
Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present.

Code 2 of a code pair that is not allowed by NCCI even if appropriate modifier is present.
Medical visit on same day as type T or S procedure without modifier 25.
Invalid modifier
Invalid date
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.
OCE035  Only Mental Health education and training services provided.

OCE036  Terminated bilateral procedure or terminated procedure with units greater than one.
         Inconsistency between implanted device or administered substance and implantation or
         associated procedure.
OCE038  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.
         Observation does not meet minimum hours, qualifying diagnoses, and or T procedure
         conditions.
OCE052  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.
         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
OCE075 Incorrect billing of modifier FB or FC
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
P01 Member Not On File
P02 Provider Not on File
P03 No Enrollment
P123 Possible TLP claim/auth
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
R1118 A modifier is required for this service.
R173 Diagnosis Code on Claim does not Match Term
R180 No Employer Fee For Service
R203 Service is excluded from benefit plan.
R204 CRNA/Anesthesiologist Assistant requires modifier QX/QZ.
R205 Provider Type invalid for POS 03.
R206 Therapy Services Require a Modifier.
R207 Portable X-Ray Services Require Modifier.
R208 Service requires modifier UA.
R209 Service(s) require modifiers UC and UA.
R210 Physical/Occupational/Speech Therapy Services Require Modifier.
R211 Not a covered revenue code with bill type 12x.
R213 Services are non-covered
R217 Claim processed according to any one of the following guidelines: Provider Contract,
State/CMS fee schedule, and/or Coordination of Benefits
R219 Provider overlaps global days period
R221 Invalid Procedure code for Medicare
R223 Charges are Paid for by Medicaid FFS
R224 Payment for this service is included with the payment for the Ambulatory Surgery Center
facility charge.
R301 Primary Insurance Payment Information Not Submitted With Secondary Claim
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  
R310  Other agency may be responsible for payment  
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  
R326  Services requires correct modifier.  
R327  Services are considered NonCovered as submitted.  
R328  SNF benefit valid within 14 days of inpatient hospital stay  
R329  Services Require a Modifier.  
R330  Revenue code 0637 for self administered drugs is a non-covered service.  

Remit  SERVICES ARE NONCOVERED  
RG376  Services processed according to Contract case rate.  
RHQ01178  Re-Processed Claim from Denial  
S12  Services are considered NonCovered as submitted.  
TST293  Services Require a Modifier.  
zzz  Services are considered NonCovered as submitted.