reasonid	reporttext
	No Reason
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.

D13	Incorrect authorization number.
D14	Service Requires Authorization
D15	Member Not Enrolled on Date Of Service.
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.
D44	Please resubmit claim with ER report.
D45	Adjust to authorized level of care.
D46	No response to COB inquiry.
D47	Resubmit with OP report.
D48	Requires H&P.
D49	Please resubmit claim with physician notes.
D50	Included in OB package.
D51	Please resubmit claim with a copy of the consult report.
D52	Resubmit with dialysis reports.
D53	Split billing required.
D54	Itemized statement required.
D55	Authorization number invalid for DOS.
D56	Revenue code missing / invalid.
D57	DOS incorrect.
D58	Need ambulance EMS report.
D59	Requires discharge summary.
D60	Claim has been denied. At DOS, assigned to other PCP.
D61	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 wth 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.
i059	Services are not covered.
i060	Claim does not meet Medicare guidelines for Inpatient Part B benefits.
i061	Invalid Modifier for Date Of Service.
i062	Invalid UB Occurrence Code on DOS.
i063	Invalid UB Occurrence Span Code on DOS.
i064	Invalid UB condition on DOS.
i065	Invalid UB Value on DOS.
i066	APC-Packaged Service.
i067	Resubmit claim with valid rendering provider.
i068	Non-Covered-Not a valid Medicare code.
i069	Claim denied as patient cannot be identified as our insured
i070	Corrected Claim
i071	Corrected claim, services not rendered
i072	Missing/incomplete/invalid taxonomy.
i073	Invlaid DRG Submitted
i074	Valid revenue code required for Skilled Nursing claim submissions
i075	Self-administered drugs are not covered
i076	Adjusted - incorrect member/patient.

i077	Processed according to the LTC contract or authorization.
i078	Adjustment-Correction to Deductible/Co-pay
i079	Adjustment-Correction to a previously processed claim
i080	Deny – Medicare Statutory Excluded Services.
i081	Home Health: "Processed according to LUPA/CMS guidelines"
i082	ESRD: "Processed according to CMS/State ESRD guidelines"
i083	Skilled Nursing: Processed according to CMS/State RUGs guidelines
i084	IRF: Processed according to the CMS Inpatient Rehab Facility billing guidelines
i085	Prior Authorization On File Is Not For The Same Provider
i086	Prior Authorization On File Is Not For The Same Date Of Service
i087	Drug Description Required And/Or Self Administered Drug Not Covered
i088	Services Are Not A Covered Benefit When A Claim Is Submitted With This Bill Type.
i089	Service(s) Are Not A Covered Benefit.
i090	Stays of less than 24 hours are considered Outpatient
i091	Provider Billing Error
i092	This is a duplicate claim, the original claim is in process
i093	Other Insurance Coverage Exists For Service Line Date.
i094	Procedure Code Not Found Or Invalid For Date Of Service
i095	Inpatient Days Exceeds Maximum For Covered Benefit.
i096	Additional Payment Made on a Previously Processed Claim
i097	Missing/Invalid/Incomplete TIN
i098	Adjustment project – adjustment to a previously processed claim.
i099	Adjustment includes coordination of secondary benefits.
i100	This is a Measurement code for reporting purposes only.
i101	Claims prior to 12/4/2011 are included in the settlement agreement and are not eligible for payment.
i104	The date of service is outside of the contract benefits.
i105	Adjustment to correct previously submitted diagnosis code.
i106	This HIPPS RUGS service line should not have a dollar amount in the billed charges field.
i107	Provider type does not match benefit requirement.
i108	Payment amount reflects 2% Medicare Sequestration reduction
i109	Reimbursement for this service is based on ForwardHealth's reimbursement reduction provision.
i110	Critical Access Hospital (CAH)- Resubmit claim with CMS Rate Letter.
i111	Claims with dates of service in 2011 are included in the settlement agreement and are not eligible for payment
i112	Claim adjusted based on DRG review.
i113	EOB does not match current claim information being submitted
i114	Missing/Incomplete information submitted on prior Insurance Carrier(s) EOB
i115	Per ForwardHealth guidelines, claims for outpatient therapy services for Medicaid prime members must be billed on a professional HCFA form.
i116	Follow Corrected Claim Submission Process
i117	Member does not have iCare Medicaid coverage to process these Long Term Care services
i118	Submit NEMT claims to MTM Inc, the DHS Transportation HMO and Manager.

i119	Please submit to WIDA
i120	Per CMS, Ambulance transports of individuals with ESRD to and from renal dialysis treatment are reduced by 10%.
i121	Adjusted,late charges submitted
i122	Adjusted,Void/Cancel of prior claim
i123	Claims billed with the GY modifier are statutorily excluded or do not meet the definition of 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	Intermim 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 Physisian 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.
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.
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
N255	Missing/incomplete/invalid taxonomy.
N688	This reversal is due to a medical or utilization review decision.
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 paitent 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 servicxes not included in OPPS.
OCE015	Invalid/incomplete/incorrect units.
OCE016	Mulitple bilateral procedures without modifier 50.
OCE017	Inappropriate specification of bilateral procedure.
OCE018	Inpatient procedure.
OCE019	Mutually exlusive 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	Mdeical visit on same day as type T or S procedure without modifer 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 recognizedby Medicare; Alertnate 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.
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 inpaitent 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 modifer 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 hosptialization
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 cirtical care code without revenue code 068x and CPT 99291
OCE077	Claim lacks allowed procedure code
OCE078	Claim lacks required radiolabeled prodcut
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.
R530	Insufficient Units For Date Span
Remit	SERVICES ARE NONCOVERED
RG376	Services processed according to Contract case rate.
RHQ01178	Re-Processed Claim from Denial
S12	SNF benefit valid within 14 days of inpatient hospital stay
TST293	Services are considered NonCovered as submitted.
TSTMod	Services Require a Modifier.
zzz	Revenue code 0637 for self administered drugs is a non-covered service.