Reason Codes and Descriptions

CODE	DESCRIPTION
04	Expense not covered by plan
06	Inmate not eligible
13	PPO Benefits applied
24	Duplicate charge
27	Claim adjustment
32	Paid by previous carrier
36	Duplicate of a corrected claim
40	Additional payment
42	Inmate responsible for charges
44	Not covered, member responsible
45	Refile with physicians name
46	Prior to effective date of group
47	Submit itemized statement
48	Inclusive with per Diem rate
50	Submit entire medical record
51	Amount previously billed
57	Not a state inmate
65	Late charges are not covered
67	Other coverage primary
82	Corrected EOB
95	Claim denial upheld
96	Inmate on medical furlough
107	Corrected claim received
108	Does not change amount paid
114	Cannot bill assistant surgeon charges
121	Inmate paroled
123	Invalid CPT code- resubmit
130	Diagnosis not valid for sex
131	Newborn care is not covered
137	Included in case rate

CODE	DESCRIPTION
139	Included with DRG rate
146	No allowance for modifier 26
150	Convenience items not covered
151	After hours charges not covered
153	Invalid age for CPT code
154	Invalid sex for CPT code
155	Invalid place of service
156	Invalid modifier code
157	Invalid diagnosis code
158	Invalid age for diagnosis
159	Unacceptable primary diagnosis
160	Incidental procedure
161	Charge included in another code
162	CPT not valid for service date
163	Included in global time period
164	Possible catastrophe
165	Included in global allowance
166	Not medically necessary
167	Elective procedure not covered
168	Cosmetic procedure non covered
169	Secondary Diagnosis required
170	Non-specific Primary Diagnosis
171	Invoice required for payment
172	Claim paid by CCHCS
173	Resubmit Claim with DRG code
174	Not eligible
177	Page 1 of 2 missing, resubmit
178	Page 2 of 2 missing, resubmit
179	Submit additional documentation
184	Resubmit claim by fiscal Year
186	Claim returned to CCHCS
187	Multiple pages missing, re-bill
188	Resubmit with CPT code

CODE	DESCRIPTION
190	No diagnosis code submitted
191	Please resubmit with diagnosis
192	Bill lacks required modifier/CPT code
193 & 194	Code is a component of another; not allowable
195 & 196	Code not recognized by OPPS; alternate code available; re-bill
197	Resubmit Corrected Billing
202	CPT/Procedure code not allowable
203	Invalid bill type; resubmit
204	Inclusive with Base Rate
205	Multiple surgery reduction
206	Invalid use of modifier
207	Incidental charges reported, re-bill
208	Provide pick up address and zip
209	Submit anesthesia code
210	Units exceed medical necessity
211	Not eligible per CCHCS contract
212	No RVP for this procedure
213	Inappropriate use of modfier
214	Covered inpatient service only
215	CPT does not match description
218	Invalid tax ID
219 & 220	Inappropriate specification of Bilateral procedure OCE
221	Claim lacks required device code
222	EDI-No tax ID submitted on claim
223	Re-bill on HCFA 1500 claim form
224	Service not billable to FI/MAC
225	Provide service facility address
226	Requires HCPCS on same line
227	No payee data record
228 & 229	Resubmit with height & weight of patient
230	Dental service not covered
231	Covered w/ condition code only
232	Non allowed service for OPPS

CODE	DESCRIPTION
233	Future service not payable
234	Registry charge returned to CCHCS
235	DME/Orthotics covered by CCHCS
236	Surgeon cannot bill as assistant
237	Condition code required on bill
238	CCHCS refund received
239	Resubmit with only one base rate
240	No charges were submitted
241	Billable by hospital only
242	EDI- No inmate Name submitted
243	EDI -No CDCR number submitted
244	Claim lacks required device code
245	Code not recognized by Medicare
246	Code only billable to DMERC(RTP)
247	Verify Date of Service submitted
248 & 249	Previously paid as Assistant Surgeon
250	Units > 1 is inappropriate
251	Invalid revenue code
253 & 254	Incorrect billing of blood or blood products
255	Trauma response w/ critical care
256	Requires REV code with CPT code
257 & 258	Re-bill using procedure(s) code(s) as contracted
259 & 260	Please submit Medicare Fiscal Intermediary letter.
261	Statutory exclusion list and not
262	covered by Medicare outpatient
263	Co-Surgeon not permitted
264	ADJ-01 not completed/signed
265 & 266	Incorrectly billed address in box 33, please resubmit
267	Admin Days denied by CCHCS
268 & 269	Mutually exclusive to another CPT code billed
270	Submit supporting documentation
271	Per CCHCS UM inmate ineligible
272	Per DH at CCHCS

CODE	DESCRIPTION
273 & 274	Additional paid to contracted rate
275	NDC Code required for payment
276	No inmate name submitted
277 & 278	Inmate not seen on Date of Service
279 & 280 & 281	DRG submitted does not match CMS group DRG code; submit corrected DRG code
282 & 283	Claims with handwritten information are not accepted
284 & 285	Administrative fee included in reimbursement
286 & 287	Re-bill Health Net, date of service on new claim
288	Services packaged into PAC rate
289	Medicare non-covered item / service
290 & 291	Claim lacks required device code radio labeled product, resubmit
292	Clinical diagnostic lab services
293 & 294	Claim service crosses contract with PPO, please split and re-bill
295 & 296	Incidental services packaged into APC rate
297	Adjustment / refund error
298	NDC submitted is invalid
299	Not approved per ADJ- 01 form
300 & 301	Add on code not reimbursable because valid primary CPT absent
302	Invalid age/gender for CPT code
303	Invalid age/gender for HCPCS
304 & 305	E&M service previously paid for DOS, only one allowed per day
306 & 307 & 308	Patient seen within last 3 yrs by physician, submit established CPT code
309 & 310 & 311	Patient seen within last 3 yrs by physician, an established code was reimbursed
312 & 313 & 314	Included in global surgical package for major surgery and is not separately reimbursable
315 & 316 & 317	Included in global surgical package for minor surgery and is not separately reimbursable
318 & 319 & 320	This procedure is incidental to another service on this Date of Service and is notreimbursable
321 & 322	This service is not reimbursable based on the place of service
323	This service is not covered
324 & 325 & 326	As assistant surgeon, co- surgeon for this CPT requires additional documentation
327 & 328 & 329	An Assistant Surgeon, Co- Surgeon or Team Surgeon for this CPT requires additional documentation
330 & 331 & 332	Procedure submitted with more than one multiple surgeon modifier
333	Invalid modifier for procedure

CODE	DESCRIPTION
334	Duplicate charge
335 & 336	Exceeds the appropriate number of units per day
337 & 338	Exceeds the appropriate units for defined time frame
339 & 340	Component included with other CPT billed for Date of Service
341 & 342	Mutually exclusive to another procedure billed
343 & 344	Unlisted procedure requires additional documentation
345 & 346	Not medically necessary based on National Coverage Determination
347 & 348	Included in global obstetric package
349 & 350	Procedure is part of a lab panel and is not reimbursable
351 & 352	CPT is add on code and cannot be billed as a standalone code
353 & 354	Included in global surgical package for another CPT billed
355 & 356 & 357	Status B code payment included in payment for other services on same Date of Service
358	Invalid diagnosis code
359 & 360	Status T code included in other CPT payment for same DOS
361 & 362 & 363	Another E&M service billed for same provider and same DOS this CPT will not be reimbursed
364 & 365	Global period applies, same CPT billed with previous DOS
366	Refund received and applied
367 & 368	CPT code not valid for date of service billed
369 & 370	Unlisted procedure or service is not reimbursable
371 & 372 & 373	CPT submitted with multiple units exceeding the CMS Medically Unlikely edit
374 & 375	CPT/HCPCS is not valid for date of service submitted on claim
376	Invalid diagnosis code submitted
377 & 378	Submit supporting medical documentation
379	Invalid principle DX code
380	Service not separately payable
381 & 382	Code 2 of a Code1 / Code2 paid; needs modifier
383	Service units out of range
384	Invalid HCPCS code
385	Modifier required for payment
386 & 387	Diagnosis code requires ALS HCPCS code
388 & 389	Not payable due to invalid base rate HCPCS code
391	Revenue code requires HCPCS code
392	Packaged / Incidental services

CODE	DESCRIPTION
393	Invalid bill type
394	Invalid Place of Service
395	Excluded from negotiated rate
396 & 397 & 398	Provider compensation for this service is zero per Coventry Provider agreement
399 & 400 & 401	Multiple medical visits, same revenue code, same date without condition code G0
402 & 403	No additional payment due, included with additional pricing
404	Claim lacks required device code
405 & 406	Claim lacks required radiolabeled product
408	Invalid principle procedure
409	Procedure/Sex conflict
410 & 411	Procedure may only be performed in an inpatient setting
412 & 413	Place of Service not valid for procedure billed
414	Invalid procedure to modifier
415 & 416 & 417	Lab test is component of a lab panel and requires being billed using the panel code
418 & 419	HSS ASC invalid Bill Type or Place of Service
420 & 421 & 422	Provider is not contracted for services submitted with this Bill Type/POS
423 & 424	Medical visit with procedure without 25.
426	CMS rates not available
427 & 428	Original bill required to price late charges
429 & 430	Inpatient service not paid under OPPS
431 & 432	Packaged service/item; no separate payment
433 & 434	Service not covered by Medicare for free standing ASC
435 & 436	Component of comprehensive procedure not allowed
437 & 438	Service not billable to the Fiscal intermediary
442	Invalid ICD Procedure codes used.
443	Additional charges added.
444	Charges billed as non- covered.
447	No allowance for Asst. Surgeon.
448	NPI number does not match.
449	Physician in box 31.
450	Therapy service requires modifier
451	Invalid principal diagnosis
452 & 453	Present on admission POA codes are missing

CODE	DESCRIPTION
454	Not Medically necessary based on
455	Local Coverage Determination.
456 & 457	NDC submitted has been deactivated for this DOS
458	Status N code is non- covered
463 & 464	Remit address does not match BIS account information on le
470 & 471	Incidental procedure not separately reimbursed
472 & 473	Resubmit claim with correct NPI number
475	Discharge status is invalid
481	Invalid or missing CMG code
484	G0379 only allowed with G0378
487 & 488	Service provided same day as an inpatient procedure
493 & 494	Vendor should re-bill through the hospital/surgery ctr/phy
500 & 501 & 502	Packaged surgical procedures include operation & uncomplicated post-op care
503	Non-covered inmate is a donor
506	RUG values missing
507	CCHCS UM Audit required
511	Invalid DRG code
513 & 514 & 515	Line 1 does not match the date of service billed in the statement period submitted
516 & 517	Line service date is invalid in box 32 for Place of Service
518	Incorrect Bill Type
519 & 520	Admission Source Code, box 15 missing or invalid
568 & 569	Inappropriate specification of bilateral procedure.
577 & 578 & 579	Occurrence code, assessment date for each period billed must be submitted.
580	HCPCS invalid for Revenue Code.
586 & 587	Submit claim to CCHCS for processing.
592 & 593 & 594	Skin Substitute application procedure w/out appropriate skin substitute product code.
595	HPSA Bonus Applied
607 & 608 & 609	ICD9 and ICD10 Dates of service cannot be billed on same 1500 form (02-12)
613	Bill to U.S. Marshal office
647 & 648 & 649	Claim with pass-through or non pass-through drug or biological lacks OPPS payable procedure.
685 & 686	Documentation does not support billing per UM
719 & 720 & 721	Consolidated Transfusions/Blood Exchanges require Blood product.
723 & 724	POS billed is invalid for CCHCS contract.

CODE	DESCRIPTION
750 & 751	Biosimilar HCPCS reported without biosimilar modifier.
778	Corrected claim received – PPAR
815 & 816	Valid PDPM/HIPPS code required for processing.
821 & 822	Provider not contracted for services
826 & 827	Not 24 hr stay, covered under OPPS, rebill per OPPS.
859 & 860	Does not support Major Complication or Comorbidity, Care
861 & 862	Does not support Complication or Comorbidity
863 & 864	Does not meet criteria for Inpatient stay
866 & 867 & 868	Observation code G0378 not allowed to be reported more than once per claim.
876	Incorrect patient name
877	Incorrect CDCR number
878	No movement on DOS
879	Not in CDCR custody on DOS
880	Unable to verify identity
881	Unable to verify episode of care
901 & 902 & 903	Documentation submitted does not support the billing per dental review
904	TAR not on file
905	TAR not approved
912 & 913 & 914	Incorrect Admin Day form-Please resubmit with form ADJ-01 June 2022
916 & 917 & 918	Denied for Phase III Medi-Cal Eligibility-Submit claims to Dept of Health Care Services.
989 & 990	Requires CMS allowable comparable code.
991 & 992	Submit records with start/stop time.
993 & 994	InterQual Criteria not met for DRG.
995 & 996 & 997	Round trips must be billed separately, one base rate per claim.
998 & 999	Diagnosis codes billed not supported by documentation.
1011 & 1012	Documentation does not support the level of care.
1013 & 1014	Documentation does not support the DRG billed.
1015 & 1016 & 1017	Denied due to DJJ Realignment/Closure -Submit claims to the county where the patient is located.
1020 & 1021	Documentation does not support the primary diagnosis code.
1028	BIS unable to withhold 7%.