

EX Code and Reason/Remark Code Cross Reference

EX Code	EX Code Description	Reason Code	Reason Code Description	Remark Code	Remark Code Description
04	PAID-FACILITY PAYMENT INCLUDED IN DRG/PERDIEM/GLOBAL RATE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		
05	CLAIM PROCESSED - PAYMENT REFLECTS USUAL AND CUSTOMARY CHARGES	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
06	FEE SCHEDULE OR DISCOUNT - PAYMENT IN FULL	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
07	PAID TO AUTHORIZED LIMIT	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
08	SERVICE ADJUSTED - BASED ON OTHER INSURANCE OR MEDICARE EOB	23	The impact of prior payer(s) adjudication including payments and/or adjustments.		
10	NEWBORN CHARGES PROCESSED ON MOTHER'S CLAIM	128	Newborns services are covered in the mothers Allowance.		
11	CAPITATED SERVICE	24	Charges are covered under a capitation agreement/managed care plan.		
12	ORIGINALLY SUBMITTED PROCEDURES HAVE BEEN COMBINED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		
15	ORIGINALLY SUBMITTED PROCEDURE HAS BEEN MODIFIED/REDUCED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
16	PAID - MANUALLY PRICED, INDIVIDUAL CONSIDERATION PROCEDURE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
20	PAID-DEDUCTIBLE APPLIED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
21	PAID-COINSURANCE APPLIED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
22	PAID-COPAY APPLIED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
23	DENY - DATE OF SERVICE REPORTED IS A FUTURE DATE	110	Billing date predates service date.	M52	Missing/incomplete/invalid "from" date(s) of service.
27	DENY - INPATIENT DAYS DO NOT MATCH UNITS REPORTED - DTR 1202	125	Submission/billing error(s). At least one Remark Code must be provided.	M53	Missing/incomplete/invalid days or units of service.
28	DENY-MORE DESCRIPTIVE DIAGNOSIS CODE IS NEEDED	125	Submission/billing error(s). At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
29	DENY-NO CPA ON FILE - DTR 901	226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided	M135	Missing/incomplete/invalid plan of treatment.
30	DENY-PROVIDER NOT ELIGIBLE TO PROVIDE SERVICE	185	The rendering provider is not eligible to perform the service billed.	N289	Missing/incomplete/invalid rendering provider name.
31	DENY - MEDICAL OR OUTPATIENT SERVICE SPAN EXCEEDS 31 DAYS	95	Plan procedures not followed.	M139	Denied services exceed the coverage limit for the demonstration.
32	PAY-CHEMICAL DEPENDENCY COUNTY ASSESSMENT REVIEW APPROVAL	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
33	DENY-SERVICE'S BILLED DO NOT MATCH PROVIDERS FEE SCHEDULE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
34	DENY-MODIFIER WAS NOT SUBMITTED WITH CLAIM FOR PRICING	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
50	DENY - INVALID CLAIM/SERVICE - DTR 1202	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
51	MEMBER HAS OI(OTHER INSURANCE)ON FILE, DTR 801	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
52	DENY - PAYMENT INCLUDED IN ALLOWANCE FOR ANOTHER PROCEDURE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
54	DENY-PAID BY OTHER CARRIER	23	The impact of prior payer(s) adjudication including payments and/or adjustments.	N23	Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
57	DENY - AUTHORIZATION LIMITATION EXCEEDED	198	Pre-certification/authorization exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.
58	PEND-AUTHORIZATION REQUEST NOT APPROVED	133	The disposition of this claim/service is pending further review.		
59	PEND - NO AUTHORIZATION ON FILE	89	Professional fees removed from charges.		
60	PEND-DIAGNOSIS IS INCONSISTENT WITH PATIENT'S AGE	69	Day outlier amount.		
61	PEND-DIAGNOSIS IS INCONSISTENT WITH PATIENT'S GENDER	70	Cost outlier - Adjustment to compensate for additional costs.		

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62	PEND-PROCEDURE IS INCONSISTENT WITH PATIENT'S AGE	69	Day outlier amount.		
63	PEND-PROCEDURE IS INCONSISTENT WITH PATIENT'S GENDER	70	Cost outlier - Adjustment to compensate for additional costs.		
64	DENY - PROCEDURE INCONSISTENT WITH DIAGNOSIS - DTR 1202	11	The diagnosis is inconsistent with the procedure.		
65	PEND-MISSING OR INVALID INFORMATION	90	Ingredient cost adjustment.		
71	DENY-MEMBER NOT ELIGIBLE ON DATE OF SERVICE	200	Expenses incurred during lapse in coverage		
73	DENY-PRE-EXISTING CONDITION	51	These are non-covered services because this is a pre-existing condition		
76	DENY - MAXIMUM BENEFIT HAS BEEN PAID - DTR 701	119	Benefit maximum for this time period or occurrence has been reached.		
81	DENY-LIABILITY OF ANOTHER CARRIER	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
83	DENY - DUPLICATE OF PREVIOUS SUBMITTED CLAIM	18	Duplicate claim/service.		
85	PEND-SERVICE IS COVERED BY THE STATE PROGRAM/FFS MEDICARE	88	Adjustment amount represents collection against receivable created in prior overpayment.		
86	DENY - RESUBMIT SERVICE ON CMS 1500 - DTR 1202	125	Submission/billing error(s). At least one Remark Code must be provided.	N34	Incorrect claim form/format for this service.
87	DENY - CAPITATED SERVICE	24	Charges are covered under a capitation agreement/managed care plan.		
91	DENY - RESUBMIT TYPEWRITTEN CLAIM	125	Submission/billing error(s). At least one Remark Code must be provided.	N205	Information provided was illegible
93	PEND-SERVICE NOT MEDICALLY NECESSARY	82	PIP days.		
94	DENY-SERVICE IS EXPERIMENTAL	55	Procedure/treatment is deemed experimental/investigational by the payer.		
95	PEND-PER MEDICAL REVIEW	133	The disposition of this claim/service is pending further review.		
97	DENY-SERVICE COVERED UNDER CAPITATED ARRANGEMENT	24	Charges are covered under a capitation agreement/managed care plan.		
98	DENY-SERVICE SHOULD BE SUBMITTED TO PBM	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N418	Misrouted claim. See the payer's claim submission instructions.
99	DENY - PRIMARY INSURANCE CARRIER HAS REQUESTED ADDITIONAL INFO	136	Failure to follow prior payers coverage rules. (Use Group Code OA).		
9Z	DENY - RESUBMIT BILL UNDER INDIVIDUAL PROVIDER - DTR 901	125	Submission/billing error(s). At least one Remark Code must be provided.	N256	Missing/incomplete/invalid billing provider/supplier name.
A0	APC - PROCESS SUCCESSFUL	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
A1	APC - OCE LINE ITEM REJECTION	125	Submission/billing error(s). At least one Remark Code must be provided.	N180	This item or service does not meet the criteria for the category under which it was billed.
A2	APC - OCE LINE ITEM DENIAL	125	Submission/billing error(s). At least one Remark Code must be provided.	N180	This item or service does not meet the criteria for the category under which it was billed.
A4	APC - OCE CLAIM LEVEL "RETURN TO PROVIDER" (RTP)	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
A5	APC - OCE CLAIM LEVEL REJECTION	125	Submission/billing error(s). At least one Remark Code must be provided.	N180	This item or service does not meet the criteria for the category under which it was billed.
A6	APC - OCE CLAIM LEVEL DENIAL	125	Submission/billing error(s). At least one Remark Code must be provided.	N180	This item or service does not meet the criteria for the category under which it was billed.
AD	DENY - REQUIRED MODIFIER WAS NOT SUBMITTED WITH CLAIM	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
AJ	DENY - DIAGNOSIS IS REQUIRED RESUBMIT WITH VALID DIAGNOSIS	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
AK	ADJUSTMENT/REVERSAL	129	Prior processing information appears incorrect.	MA67	Correction to a prior claim.
AL	APC - INCORRECT CODING OF LAB PANEL COMPONENTS	125	Submission/billing error(s). At least one Remark Code must be provided.	M126	Missing/incomplete/invalid individual lab codes included in the test.
AP	APC - PACKAGED SERVICE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		
AQ	ADJUSTMENT - COB EOP RECEIVED	23	The impact of prior payer(s) adjudication including payments and/or adjustments.		
AR	DENY - RESUBMIT CLAIM WITH PRIMARY PAYER EOP - DTR 801	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.

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AT	REVERSAL - CLAIM PAID TO INCORRECT PROVIDER	125	Submission/billing error(s). At least one Remark Code must be provided.	N472	Payment for this service has been issued to another provider.
AU	DENY - RESUBMIT CLAIM WITH PROVIDER'S FULL NAME	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N256	Missing/incomplete/invalid billing provider/supplier name.
AV	DENY - RESUBMIT WITH SUPPORTING DOCUMENTATION	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N29	Missing documentation/orders/notes/summary/report/chart.
AW	DENY - INVALID PROVIDER - DTR 1202	185	The rendering provider is not eligible to perform the service billed.		
AX	DENY- AMBULANCE CHARGE WITH NO VALUE CODE FOR ZIP CODE PRICING	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	M49	Missing/incomplete/invalid value code(s) or amount(s).
B2	PACKAGED/BUNDLED SERVICE/INFORMATIONAL ONLY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		
BJ	DENY-BILL TO MIDWEST DENTAL	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N418	Misrouted claim. See the payer's claim submission instructions.
BK	DENY-BILL TO PRIME THERAPEUTICS, INC.	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N418	Misrouted claim. See the payer's claim submission instructions.
BN	PAY-ELDERLY WAIVER OBLIGATION HAS BEEN APPLIED	142	Monthly Medicaid patient liability amount.		
BO	DENY-ELDERLY WAIVER OBLIGATION COLLECT FROM MEMBER	1	Deductible Amount		
BX	DENY - SERVICES BILLED DO NOT MATCH CPA FORM/SERVICE EVENT LETTER	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
BZ	DENY - RATE NOT FOUND/UPDATED IN MN-ITS - DTR 901	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N153	Missing/incomplete/invalid room and board rate.
CB	DENY - DISCREPANCIES ON COB BILLING - DTR 1202	129	Prior processing information appears incorrect.		
CC	COUNTER LIMIT HAS BEEN MET PAYING ZERO	222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.		
CD	CC-REPLACE W/ESTABLISHED PATIENT PROC(NVF); SHOULD NOT BE REIMBURSED	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N22	This procedure code was added/changed because it more accurately describes the services rendered.
CE	CC-HISTORY DENIED PROCEDURE; SHOULD NOT BE REIMBURSED.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
CF	CC-REPLACED DUE TO REBUNDLING.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
CG	CC-DENIED DUE TO REBUNDLING.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
CJ	COMPANION CLAIM PRIMARY HAS BEEN ADJUSTED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
CK	CC-REPLACED DUE TO INTENSITY OF SRVS REPLACEMENT;SHOULD NOT BE REIMBURSE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N22	This procedure code was added/changed because it more accurately describes the services rendered.
CM	CC-DIAG TO PROC COMPARISON PROCEDURE DENIED; SHOULD NOT BE REIMBURSED	11	The diagnosis is inconsistent with the procedure.	M76	Missing/incomplete/invalid diagnosis or condition.
CN	CC-PROCEDURE WAS DENIED, IT WAS NOT EXPECTED WITH SUBMITTED DIAGNOSIS	11	The diagnosis is inconsistent with the procedure.	M76	Missing/incomplete/invalid diagnosis or condition.
CP	PAY - CONSENT FORM WAS RECEIVED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
CQ	CC-SMARTSUSPENSE DENIAL;SHOULD NOT BE REIMBURSED	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
CS	DENY-PLEASE RESUBMIT SERVICE WITH APPROPRIATE C&TC ALPHA REFFERAL CODE	125	Submission/billing error(s). At least one Remark Code must be provided.	N78	The necessary components of the child and teen checkup (EPSDT) were not completed.
CU	CC-CLAIMCHECK GLOBAL PAY SERVICE, REVIEW COMPLETE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
CV	CC-DUPLICATE PROCEDURE DENIED SHOULD NOT BE REIMBURSED	18	Duplicate claim/service.	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
CY	DENY - INCORRECT PROVIDER BILLED - CYD TO RESUBMIT CLAIMS	208	National Provider Identifier - Not matched.		
D1	CC-DENY PROCEDURE NOT INDICATED FOR GENDER ON CLAIM	7	The procedure/revenue code is inconsistent with the patients gender.		
D2	THIS CARE WAS AVAILABLE AT A HEALTH PLAN PROV - DTR 101	38	Services not provided or authorized by designated (network/primary care) providers.		

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D4	THIS PROVIDER IS NOT IN OUR HEALTH PLAN NETWORK - DTR 201	38	Services not provided or authorized by designated (network/primary care) providers.		
D5	THIS PROVIDER IS NOT ELIGIBLE TO PROVIDE THIS SERVICE - DTR 205	185	The rendering provider is not eligible to perform the service billed.		
D6	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 301	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
D7	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 302	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
D8	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 303	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
D9	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 304	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
DA	THIS CARE WAS AVAILABLE AT A HEALTH PLAN PROVIDER - DTR 102	38	Services not provided or authorized by designated (network/primary care) providers.		
DB	CC-DENY PROCEDURE IS CLASSIFIED AS OBSOLETE	181	Procedure code was invalid on the date of service.		
DC	DENY - DUPLICATE CHARGE, ORIGINAL UNDER REVIEW	18	Duplicate claim/service.		
DH	CC-DENY INCIDENTAL PROCEDURE; SHOULD NOT BE REIMBURSED.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N19	Procedure code incidental to primary procedure.
DJ	CC-DENY CCI MUTUALLY EXCLUSIVE PROCEDURE; SHOULD NOT BE REIMBURSED.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
DK	CC-DENY CCI INCIDENTAL PROCEDURE; SHOULD NOT BE REIMBURSED.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N19	Procedure code incidental to primary procedure.
DN	CC-DENY MUTUALLY EXCLUSIVE PROCEDURE; SHOULD NOT BE REIMBURSED.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.

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DO	DENY - OUT OF NETWORK - DTR 201	38	Services not provided or authorized by designated (network/primary care) providers.		
DQ	DENY - MULTIPLE DUPLICATE SERVICES FOUND	18	Duplicate claim/service.		
DR	DENY - DAILY RATE HAS BEEN MET THROUGH PREVIOUS CLAIM SUBMISSION	18	Duplicate claim/service.		
DS	CC-DENY POST OPERATIVE PROCEDURE; SHOULD NOT BE REIMBURSED.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
DT	CC-DENY PRE OPERATIVE PROCEDURE; SHOULD NOT BE REIMBURSED.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
DU	PAY -	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
DV	CC-DENY MEDICAL VISIT PROCEDURE; SHOULD NOT BE REIMBURSED.	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
DW	CC-DENY PROCEDURE NOT INDICATED FOR AGE OF PATIENT ON CLAIM	6	The procedure/revenue code is inconsistent with the patients age.	N30	Patient ineligible for this service.
DY	DENY - DUPLICATE CLAIM	18	Duplicate claim/service.		
E6	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 311	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
E7	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 312	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
E8	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 313	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
E9	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 314	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.

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EA	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 305	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
EB	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 306	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
EC	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 307	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
ED	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 308	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
EE	NOT MEDICALLY NECESSARY. YOUR MED RECORDS DO NOT SUPPORT - DTR 309	50	These are non-covered services because this is not deemed a medical necessity by the payer.	M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
EM	INVALID COMBINATION OF HCPCS MODIFIERS	125	Submission/billing error(s). At least one Remark Code must be provided.	N519	Invalid combination of HCPCS modifiers.
EW	CAPITATED SERVICE	24	Charges are covered under a capitation agreement/managed care plan.		
F2	THE RECORDS SENT TO US DO NOT MEET THE COV CRITERIA - DTR 713	150	Payer deems the information submitted does not support this level of service.	N163	Medical record does not support code billed per the code definition.

PrimeWest Health
EX Code/Reason Codes

F3	MORE INFO IS NEEDED FROM YOUR PROVIDER - DTR 901	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
F4	MORE INFO IS NEEDED FROM YOU BEFORE WE CAN MAKE A DECISION - DTR 902	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N29	Missing documentation/orders/notes/summary/report/chart.
F5	MORE INFO IS NEEDED. TOOTH SURFACE IS NOT VALID - DTR 903	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N29	Missing documentation/orders/notes/summary/report/chart.
F6	MORE INFO IS NEEDED. TOOTH ARCH OR QUADRANT IS NOT VALID - DTR 904	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N29	Missing documentation/orders/notes/summary/report/chart.
F7	MORE INFO IS NEEDED. XRAYs ARE NEEDED FOR SERVICE REPORTED - DTR 905	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N29	Missing documentation/orders/notes/summary/report/chart.
F8	THIS SERVICE OR ITEM IS NOT COVERED IN YOUR BENEFIT SET - DTR 1106	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
F9	THIS SERVICE OR ITEM IS NOT COVERED BY THE HEALTH PLAN - DTR 1102	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
FA	YOUR DESIGNATED PROV DID NOT ALLOW A REFERRAL FOR THIS SERV - DTR 407	165	Referral absent or exceeded.	N335	Missing/incomplete/invalid referral date.
FI	FIX SERVICE BITS	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
FM	DENY - FINANCIAL INFORMATION REQUIRED	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal right
FX	FACILITY DRG/PER DIEM/GLOBAL RATE - PAYMENT +2% TAX IN FULL	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		
G1	THIS SERVICE OR ITEM IS COVERED IN YOUR BENEFIT SET - DTR 1103	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
G2	COSMETIC SERVICES ARE NOT COVERED BY YOUR HEALTH PLAN - DTR 1104	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N383	Services deemed cosmetic are not covered
G3	PORCELAIN CROWNS ARE NOT COVERED UNDER YOUR PLAN - DTR 1108	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
G4	THIS SERVICE IS NOT COVERED BY THE HEALTH PLAN - DTR 1112	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
G5	THIS SERVICE OR ITEM IS INCLUDED IN THE DAILY RATE - DTR 1201	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N390	This service/report cannot be billed separately.
G9	WE WERE INFORMED THAT THE SERVICE WAS NOT PROVIDED - DTR 1213	112	Service not furnished directly to the patient and/or not documented.		
GL	DENY - PAYMENT INCLUDED IN DRG/PERDIEM/GLOBAL RATE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N390	This service/report cannot be billed separately.
GY	PAY - DUE TO DISCLAIMER CODE, COB DATA IS NOT REQUIRED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
H1	WE WERE INFORMED THAT THE ITEM WAS RETURNED - DTR 1214	112	Service not furnished directly to the patient and/or not documented.		
H2	YOU ARE IN THE RESTRI RECIP PROG-SERV NOT PROV BY DESIGN PROV - DTR 1215	38	Services not provided or authorized by designated (network/primary care) providers.		
H3	YOUR PROV REQUESTED A QUAN LARGER THAN ALLOWED - DTR 1401	39	Services denied at the time authorization/pre-certification was requested.		
H4	THIS A NON-FORMULARY MED - DTR 1402	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.
H5	THIS IS NOT A COVERED DRUG - DTR 1403	204	This service/equipment/drug is not covered under the patient's current benefit plan		
H6	YOUR MEDICATION WAS DENIED BECAUSE YOU DID NOT MEET CRITERIA - DTR 1404	39	Services denied at the time authorization/pre-certification was requested.		
H7	YOUR MED WAS DENIED BECAUSE THE DRUG IS EXCLUDED FROM PLAN - DTR 1405	39	Services denied at the time authorization/pre-certification was requested.		

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H8	YOU RECEIVED MORE SERVICES THAN WERE APPROVED - DTR 403	198	Precertification/authorization exceeded.	N54	Claim information is inconsistent with pre-certified/authorized services.
H9	NO RECORD OF AN APPROVAL OF HOSP STAY THAT MATCHES BILL - DTR 404	15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	M62	Missing/incomplete/invalid treatment authorization code.
HD	HISTORICAL CLAIM DENIED	A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
HM	HOME CARE MEDICAL CLAIM	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
HP	HISTORICAL CLAIM PAY	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
HS	DENY - RESUBMIT BILL TO HOSPICE	B9	Patient is enrolled in a Hospice.		
IJ	DENY - COMPLETE NPI/UMPI FORM NOT ON FILE WITH PRIMEWEST	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N29	Missing documentation/orders/notes/summary/report/chart.
IL	DENY - PAPER CLAIM IS ILLEGIBLE, PLEASE RESUBMIT LEGIBLE CLAIM	125	Submission/billing error(s). At least one Remark Code must be provided.	N205	Information provided was illegible
IU	INPATIENT COVERAGE LIMIT HAS BEEN REACHED	119	Benefit maximum for this time period or occurrence has been reached.		
J1	YOU HAVE GONE OVER THE BENEFIT LIMIT FOR THIS SERVICE DTR 701	119	Benefit maximum for this time period or occurrence has been reached.		
J2	YOU HAVE OTHER INSURANCE THAT SHOULD PAY FIRST - DTR 801	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
J3	MORE INFO NEEDED. PROCEDURE CODE INVALID OR NO LONGER USED - DTR 908	125	Submission/billing error(s). At least one Remark Code must be provided.	M51	Missing/incomplete/invalid procedure code(s).
J4	MORE INFO NEEDED. DIAGNOSIS CODE IS INVALID - DTR 911	125	Submission/billing error(s). At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
J5	WE CANNOT PAY THIS SERVICE OR ITEM AS IT IS BILLED - DTR 1202	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
J6	THIS SVC ITEM HAS ALREADY BEEN PAID AS PART OF OTHER SVC - DTR 1205	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.		
J7	THIS PROVIDER IS NOT IN HEALTH PLAN NETWORK	38	Services not provided or authorized by designated (network/primary care) providers.		
L5	PAY - DUPLICATE OF PREVIOUSLY SUBMITTED SERVICE ALLOWED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
LK	DENY - RESUBMIT CLAIM WITH MORE SPECIFIC/CORRECT PROCEDURE CODE	125	Submission/billing error(s). At least one Remark Code must be provided.	M51	Missing/incomplete/invalid procedure code(s).
LZ	DENY - CHARGES PROCESSED ON ORIGINAL CLAIM	18	Duplicate claim/service.		
M3	DENY - MEMBER INELIGIBLE ON DATE OF SERVICE	27	Expenses incurred after coverage terminated.		
M8	PAY - DUE TO DISCLAIMER CODE, COB DATA IS NOT REQUIRED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
MD	PAY - DUE TO DISCLAIMER CODE, COB DATA IS NOT REQUIRED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
ME	DENY-SERVICE DENIED BY PRIMARY CARRIER	22	This care may be covered by another payer per coordination of benefits.	N36	Claim must meet primary payer's processing requirements before we can consider payment.
MH	DENY - CHARGES RELATED TO TX OF HOSPITAL-ACQUIRED CONDITION OR PME	233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.		
MK	DENY- DIAGNOSIS REQUIRES ADDITIONAL DIGITS - DTR 911	125	Submission/billing error(s). At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
ML	PAY- PAID MANUALLY	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
MU	DENY - UNITS IN EXCESS OF MUE CRITERIA	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N362	The number of Days or Units of Service exceeds our acceptable maximum.
MV	DENY-MNVFC PROGRAM VACCINE MODIFIER MISSING	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
NB	DENY- NO NOTIFICATION OF ADMISSION	197	Precertification/authorization/notification absent.		
NH	MEMBER NOT ELIGIBLE FOR NURSING HOME COVERAGE	177	Patient has not met the required eligibility requirements.		
NI	DENY - RESUBMIT CLAIM WITH RENDERING PROVIDER'S NPI/UMPI - DTR 901	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N277	Missing/incomplete/invalid other payer rendering provider identifier.
NJ	DENY - RESUBMIT CLAIM WITH FACILITY NPI/UMPI - DTR 901	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N293	Missing/incomplete/invalid service facility primary identifier.

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NK	DENY - DIAGNOSIS 1 IS MISSING OR INVALID - DTR 911	125	Submission/billing error(s). At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
NL	DENY - NO DESCRIPTION	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N29	Missing documentation/orders/notes/summary/report/chart.
NO	CC-INVALID MODIFIER/PROCEDURE CODE COMBINATION - DENY	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
NQ	DENY - BILL TO STATE MEDICAID	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N418	Misrouted claim. See the payer's claim submission instructions.
NT	DENY - MISSING OR INVALID REFERRING PHYSICIAN NPI ON CLAIM	125	Submission/billing error(s). At least one Remark Code must be provided.	N286	Missing/incomplete/invalid referring provider primary identifier.
NU	DENY - RESUBMIT CLAIM WITH DETAILED LINE LEVEL EOB FROM PRIMARY PAYER	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
NV	DENY - PROVIDER BILLING ERROR - MULTIPLE MONTHS ON ONE CLAIM - DTR 1202	125	Submission/billing error(s). At least one Remark Code must be provided.	N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
OA	REFERRING PROVIDER IS RETIRED OR INELIGIBLE	183	The referring provider is not eligible to refer the service billed.		
OK	PAY - SERVICE OVERRIDDEN TO MAKE PAYABLE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
P0	PEND - SERVICE BILLED IN ERROR BY PROVIDER	44	Prompt-pay discount.		
P7	DENY - PRIMARY PAYMENT EXCEEDS ALLOWABLE AMOUNT	23	The impact of prior payer(s) adjudication including payments and/or adjustments.	N23	Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
PK	DENY - PROVIDER BEING REVIEWED BY STATE LICENSING BOARD	185	The rendering provider is not eligible to perform the service billed.	M143	The provider must update license information with the payer.
PU	PAY - UPON FURTHER REVIEW AUTHORIZATION NOT REQUIRED	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
PX	FEE SCHEDULE/DEFAULT - PAYMENT +2% TAX IN FULL	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
PY	PAY - COB INFORMATION HAS BEEN APPLIED	23	The impact of prior payer(s) adjudication including payments and/or adjustments.		
QP	DENY - REQUIRED QUALIFYING PROCEDURE FOR ADJUDICATION NOT PRESENT	B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.		
R8	DENY - PROFESSIONAL AND TECHNICAL SERVICES SUBMITTED BY ANOTHER PROVIDER	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M86	Service denied because payment already made for same/similar procedure within set time frame.
RE	APC - NO AVAILABLE APC/FEE SCHEDULE RATE RECORD	125	Submission/billing error(s). At least one Remark Code must be provided.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement
RF	DENY- YEARLY BENEFIT MAXIMUM EXCEEDED - DTR 701	119	Benefit maximum for this time period or occurrence has been reached.		
RI	DENY-INDIVIDUAL RENDERING PROVIDER NOT REQUIRED FOR THIS SERVICE	125	Submission/billing error(s). At least one Remark Code must be provided.	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
RN	DENY- MEMBER IS RESTRICTED	38	Services not provided or authorized by designated (network/primary care) providers.		
RO	OUTLIER AMOUNT INCLUDED IN ALLOWABLE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.		
S3	DENY - CAPITATED PROVIDER-MEMBER NOT ASSIGNED TO PHYSICIAN AND/OR CLINIC	24	Charges are covered under a capitation agreement/managed care plan.		
SF	PAY- SNF COINSURANCE AMOUNT APPLIED	23	The impact of prior payer(s) adjudication including payments and/or adjustments.		
T3	CLAIM PAID PER GRIEVANCE DECISION	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
T6	DENY - MEMBER HAS MEDICARE PART B	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
TF	DENY - FILING LIMIT EXCEEDED - DTR 1204	29	The time limit for filing has expired.		
TM	PAY - OVERRIDE TIMELY FILING DUE TO EXISTENCE OF OI	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
UD	CLAIMCHECK GLOBAL DENY	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
UE	CLAIMCHECK GLOBAL ERROR	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		

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UR	CLAIMCHECK GLOBAL REPLACE SERVICE	45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.		
US	CLAIMCHECK GLOBAL SUPERCEDE	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	N20	Service not payable with other service rendered on the same date.
VY	AUTHORIZATION DENIED IN CCMS	39	Services denied at the time authorization/pre-certification was requested.		
W1	DENY - PHYSICIAN/GROUP NOT CONTRACTED FOR RENAL CARE SERVICES	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
W2	DENY - NOT MEDICAID CERTIFIED	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
W3	DENY - PLEASE RESUBMIT WITH PHYSICIAN CERTIFICATION FORM	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
W4	DENY - AUTHORIZATION REQUEST NOT APPROVED	39	Services denied at the time authorization/pre-certification was requested.		
W5	DENY - DIAGNOSIS IS INCONSISTENT WITH PATIENT'S AGE	9	The diagnosis is inconsistent with the patients age.		
W6	DENY - DIAGNOSIS IS INCONSISTENT WITH PATIENT'S GENDER	10	The diagnosis is inconsistent with the patients gender.		
W7	DENY - PROCEDURE IS INCONSISTENT WITH PATIENT'S AGE	6	The procedure/revenue code is inconsistent with the patients age.		
W8	DENY - PROCEDURE IS INCONSISTENT WITH PATIENT'S GENDER	7	The procedure/revenue code is inconsistent with the patients gender.		
W9	DENY - MISSING OR INVALID INFORMATION - DTR 901	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
WA	DENY - PROCEDURE/MODIFIER NOT VALID ON DATE OF SERVICE	182	Procedure modifier was invalid on the date of service.		
WB	DENY - DIAGNOSIS NOT VALID ON DATE OF SERVICE	125	Submission/billing error(s). At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
WD	DENY - DIAGNOSIS 2 IS INVALID - DTR 911	125	Submission/billing error(s). At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
WE	DENY - DIAGNOSIS 3 IS INVALID	125	Submission/billing error(s). At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
WF	DENY - DIAGNOSIS 4 OR HIGHER IS INVALID	125	Submission/billing error(s). At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.
WG	DENY - BENEFIT EXCLUSION	204	This service/equipment/drug is not covered under the patient's current benefit plan	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
WH	DENY - DATE OF BIRTH FOLLOWS DATE OF SERVICE	14	The date of birth follows the date of service.		
WI	DENY - DATE OF DEATH PRECEDES DATE OF SERVICE	13	The date of death precedes the date of service.		
WJ	DENY - INVALID LOCATION/PLACE OF SERVICE	58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	N428	Service/procedure not covered when performed in this place of service.
WK	DENY - SERVICE REJECTED NEWBORN CHARGES ARE NOT COVERED	204	This service/equipment/drug is not covered under the patient's current benefit plan	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
WL		204	This service/equipment/drug is not covered under the patient's current benefit plan	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
WL	DENY - NON COVERED SERVICES - DTR 1106	204	This service/equipment/drug is not covered under the patient's current benefit plan	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
WM	DENY - RENTAL/PURCHASE GUIDELINES NOT MET	108	Rent/purchase guidelines were not met.		
WN	DENY - SERVICE IS COVERED BY THE STATE PROGRAM/FFS MEDICARE	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.hhs.gov .
WO	DENY-NOT COVERED, PROCEDURE NOT LISTED IN STATE FEE SCHED	204	This service/equipment/drug is not covered under the patient's current benefit plan	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
WP	DENY - MODIFIER IS INCONSISTENT WITH PATIENT'S AGE	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	N129	Not eligible due to the patient's age.
WQ	DENY - NON-EMERGENCY OUT OF AREA SERVICES ARE NOT COVERED	204	This service/equipment/drug is not covered under the patient's current benefit plan	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
WR	DENY - SERVICE NOT MEDICALLY NECESSARY	50	These are non-covered services because this is not deemed a medical necessity by the payer.		
WS	DENY - NOT MEDICAID CERTIFIED	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.		
WT	DENY - INVALID DIAGNOSIS	125	Submission/billing error(s). At least one Remark Code must be provided.	M76	Missing/incomplete/invalid diagnosis or condition.

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WU	DENY - INVALID MEMBER	125	Submission/billing error(s). At least one Remark Code must be provided.	MA36	Missing/incomplete/invalid patient name.
WV	DENY - INVALID FORM TYPE FOR PROCEDURE(S) SUBMITTED	125	Submission/billing error(s). At least one Remark Code must be provided.	N34	Incorrect claim form/format for this service.
WW	DENY - PROCEDURE CODE SUBMITTED IS NOT IN MEDICARE FEE SCHEDULE	125	Submission/billing error(s). At least one Remark Code must be provided.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement
WX	DENY - SERVICE NON COVERED BY PROVIDER CONTRACT	96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.
WY	DENY - SERVICE NOT COVERED DURING PRE/POST OP PERIOD- DO NOT BILL MEMBER	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
WZ	DENY - RESUBMIT ANESTHESIA CLAIM WITH PROPER ANESTHESIA CPT CODE	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	M51	Missing/incomplete/invalid procedure code(s).
XD	DENY - INVALID PROCEDURE/MODIFIER COMBINATION SUBMITTED - DTR 1202	4	The procedure code is inconsistent with the modifier used or a required modifier is missing.		
XE	DENY - RESUBMIT CLAIM WITH CORRESPONDING SURGICAL CPT CODE	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	M51	Missing/incomplete/invalid procedure code(s).
XF	DENY - CODE BILLED IS NOT COVERED FOR PROVIDER TYPE - DTR 205	8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	N95	This provider type/provider specialty may not bill this service.
XG	DENY - SERVICE MUST BE BILLED ON UB-04 OR INSTITUTIONAL FORMAT	125	Submission/billing error(s). At least one Remark Code must be provided.	N34	Incorrect claim form/format for this service.
XH	DENY - RESUBMIT CLAIM WITH THE DRUG NDC#,STRENGTH AND OR AUTHORIZATION	197	Precertification/authorization/notification absent.	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
XI	DENY - QUANTITY NOT ALLOWED FOR BILLED CODE	151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.
XJ	DENY - INVALID TYPE OF BILL	125	Submission/billing error(s). At least one Remark Code must be provided.	MA30	Missing/incomplete/invalid type of bill.
XK	TYPE OF BILL IS RESERVED PLEASE RESUBMIT WITH CORRECTION	125	Submission/billing error(s). At least one Remark Code must be provided.	MA30	Missing/incomplete/invalid type of bill.
XL	DENY - INVALID PROCEDURE CODE SUBMITTED	125	Submission/billing error(s). At least one Remark Code must be provided.	M51	Missing/incomplete/invalid procedure code(s).
XM	DENY - PROVIDER BILLING ERROR - DTR 1202	125	Submission/billing error(s). At least one Remark Code must be provided.	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
XO	DENY - SUBMIT BILL TO SKILLED NURSING FACILITY	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.
XP	DENY- SPLIT BILL- TWO DIFFERENT PAYORS FOR TIME FRAME	22	This care may be covered by another payer per coordination of benefits.	N193	Specific federal/state/local program may cover this service through another payer.
XQ	DENY - MISSING OR INVALID PRESENT ON ADMISSION INDICATOR	16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided.	N434	Missing/Incomplete/Invalid Present on Admission indicator.
XR	DENY - INVALID REVENUE CODE/PROCEDURE CODE COMBINATION	199	Revenue code and Procedure code do not match.		
XS	DENY - PROC CODE/BILL TYPE INCONSISTENT WITH PLACE OF SERVICE	5	The procedure code/bill type is inconsistent with the place of service.		
XT	DENY-INVALID TYPE OF BILL, ORIGINAL CLAIM NOT SUBMITTED	125	Submission/billing error(s). At least one Remark Code must be provided.	MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
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