# QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| 220 | 96 | {}default message{} | Non-covered charges. |
| A0626 | 39 | Authorization Status Manually Set | Services denied at the time authorization/pre-certification was requested. |
| ABCI | A1 | ABCI-Deny base code > 1 | Claim/service denied. |
| ABIL | 4 | ABIL-Inappropriate use of bilateral modifier | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| AC11 | 97 | AC11-CMO Rebundle | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| ACCI | A1 | ACCI-CCI rebundle | Claim/service denied. |
| AD11 | 97 | AD11-Rebundled Service | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| AD26 | 4 | AD26-26 Modifier Added | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| AD50 | 4 | AD50-Inappropriate use of bilateral modifier | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| AD51 | 4 | AD51-51 Modifier Added | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| ADAN | 125 | ADAN-Resubmit with Anesthesia CPT | Submission/billing error(s). |
| ADAS | 96 | ADAS-Assistant Surgeon not warranted | Non-covered charges. |
| ADBI | 4 | ADBI-Inappropriate use of bilateral modifier | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| ADCB | 18 | ADCB-Global Service previously paid | Duplicate claim/service. |
| ADDA | 9 | ADDA-Diagnosis inconsistent with patient's age. | The diagnosis is inconsistent with the patient's age. |
| ADDI | 47 | ADDI-Invalid ICD-9 Code | |
| ADDS | 16 | ADDS-Need Individual DOS | Claim/service lacks information which is needed for adjudication. |
| ADDU | 152 | ADDU-Date Units Mismatch | Payer deems the information submitted does not support this length of service. |
| ADDX | 47 | ADDX-Invalid ICD9 diagnosis code for the services reported | |
| ADEM | B20 | ADEM-One E&M/Day/Spec/Dx | Procedure/service was partially or fully furnished by another provider. |
| ADGA | 8 | ADGA-GenAnesNonAnesSpecty | The procedure code is inconsistent with the provider type/specialty (taxonomy). |

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| ADGS | A1 | ADGS-E&M or supplies within global surgical package | Claim/service denied. |
| ADIG | 4 | ADIG-Added TC or 26 Mod | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| ADIN | 97 | ADIN-Rebundled - Incidental edit | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| ADMD | 16 | ADMD-Invalid Modifier Code Submitted | Claim/service lacks information which is needed for adjudication. |
| ADME | 97 | ADME-Rebundled - Mutually Exclusive edit | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| ADMP | 4 | ADMP-Invalid modifier for procedure code | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| ADOB | 97 | ADOB-OB Global or OB Component procedure was previously paid. | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| ADPA | 6 | ADPA-Invalid procedure code for patient's age (in months) | The procedure/revenue code is inconsistent with the patient's age. |
| ADPC | 96 | ADPC-Invalid/Inactive procedure code | Non-covered charges. |
| ADPM | 119 | ADPM-Exceeds procedure maximum allowed per DOS per site. | Benefit maximum for this time period or occurrence has been reached. |
| ADPU | 119 | ADPU-Exceeds procedure allowance of one per date of service. | Benefit maximum for this time period or occurrence has been reached. |
| ADSP | A1 | ADSP-E/M Codes Same Speclty | Claim/service denied. |
| ADSU | A1 | ADSU-Supply on date of surgical procedure | Claim/service denied. |
| ADUN | 119 | ADUN-Single/unilateral procedure billed >1. | Benefit maximum for this time period or occurrence has been reached. |
| ADUP | 97 | ADUP-Rebundled - Ultimate Parent code edit | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| ADVI | 97 | ADVI-Rebundled - Visit edit | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| AGDI | 10 | AGDI-Diagnosis invalid for gender | The diagnosis is inconsistent with the patient's gender. |
| AGDP | 7 | AGDP-Service invalid for gender | The procedure/revenue code is inconsistent with the patient's gender. |
| AID4 | A1 | AID4-Diag Reg 4/5th Digit | Claim/service denied. |

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|---|---|---|---|
| ANBC | A1 | ANBC-Deny add-on no base code | Claim/service denied. |
| ANLA | A1 | ANLA-MultLineDenNewLnAdd | Claim/service denied. |
| APNP | A1 | APNP-Replace New Patient with Established | Claim/service denied. |
| APPV | 97 | APPV-PreOp/PostOp Visit included in Global surgical package | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| ARCC | A1 | ARCC-ReplConsultWithEstab | Claim/service denied. |
| ASLD | 150 | ASLD-Level 5 codes require additional documentation | Payer deems the information submitted does not support this level of service. |
| AXGA | A1 | AXGA-XwalkSurgCdToGenAnes | Claim/service denied. |
| C11 | 97 | Rebundled service | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| C1EMSD | B14 | One E&M/Day/Specialty/Diagnosis | Only one visit or consultation per physician per day is covered. |
| CALLCHG | - | Allowed Amount Greater Than Submitted Amount | - |
| CALTSV | B8 | This procedure/service is not allowed because alternative services are available. | Alternative services were available, and should have been utilized. |
| CANE1 | 59 | One anesthesia service per operative session. | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CAPP | 24 | Capitated Service. | Charges are covered under a capitation agreement/managed care plan. |
| CAPRTX | M7 | Rental Cap exceeded. | No rental payments after the item is purchased, returned or after the total of issued rental payments equals the purchase price. |
| CASNW | 54 | Assistant Surgeon not warranted. | Multiple physicians/assistants are not covered in this case |
| CAWV | 119 | Invalid IPPA/AWV billing within 12-month period. Please resubmit with the appropriate E&M code. | Benefit maximum for this time period or occurrence has been reached. |
| CBILNA | 59 | Bilateral in nature payment adjustment | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CBILP | 59 | Bilateral payment adjustment. | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |

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| CBPYMT | 97 | Payment For This Service/Item Is Bundled Into The Facility Payment | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CBUNDL | 97 | Rebundled service | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CCCI | N19 | CCI rebundle | Procedure code incidental to primary procedure. |
| CCIME | N20 | CCI rebundle - Mutually Exclusive Procedures | Service not payable with other service rendered on the same date. |
| CCOCC | 97 | Component Of Critical Care Service | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CCODE | N22 | Recoded to more accurately describe the services rendered. | This procedure code was added/changed because it more accurately describes the services rendered. |
| CCOMP | N13 | Global service component procedure adjustment. | Payment based on professional/technical component modifier(s). |
| CCON | M51 | Consult Codes Not Payable | Missing/incomplete/invalid procedure code(s). |
| CCPMG | N20 | CCI rebundle - Policy Manual Guidelines | Service not payable with other service rendered on the same date. |
| CCPTSP | B15 | CPT Separate Procedure Policy | This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. |
| CDASST | 54 | CDASST-Assistant Surgeon Not Allowed | Multiple physicians/assistants are not covered in this case |
| CDCOSU | 54 | CDCOSU-Co-Surgeon Not Allowed | Multiple physicians/assistants are not covered in this case |
| CDDX | 146 | Invalid ICD-9/ICD-10 code. | Diagnosis was invalid for the date(s) of service reported. |
| CDDXP | 11 | Invalid diagnosis code for service(s) billed. | The diagnosis is inconsistent with the procedure. |
| CDELO | N22 | Delivery only recode. No antepartum or postpartum care. | This procedure code was added/changed because it more accurately describes the services rendered. |
| CDG | A8 | CDG-Commercial DRG submitted for Medicare member | Ungroupable DRG. |

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| CDINC | 97 | Incidental service not separately payable. | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CDMEIN | M86 | CDMEIN-DME While Inpatient | Service denied because payment already made for same/similar procedure within set time frame. |
| CDMERC | M11 | Service can only be billed to the DMERC | DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's zip code. |
| CDNBC | 107 | Deny Add-on no base code. | The related or qualifying claim/service was not identified on this claim |
| CDNPI | 208 | Invalid or Inactive NPI | National Provider Identifier - Not matched. |
| CDOBS | N180 | Does not meet criteria for Observation services. | This item or service does not meet the criteria for the category under which it was billed. |
| CDPC | 18 | Duplicate of a new or deleted procedure code. | Exact duplicate claim/service |
| CDPMS | N362 | Exceeds procedure maximum allowed per DOS per site. | The number of Days or Units of Service exceeds our acceptable maximum. |
| CDPU1D | N362 | Exceeds procedure allowance of one per date of service. | The number of Days or Units of Service exceeds our acceptable maximum. |
| CDUN1 | N362 | Single/unilateral procedure billed >1. | The number of Days or Units of Service exceeds our acceptable maximum. |
| CDUP | 18 | Duplicate of previously paid claim | Exact duplicate claim/service |
| CDUPE | 18 | Duplicate of previously paid claim within 30 days | Exact duplicate claim/service |
| CDUPPD | 18 | Duplicate of previously paid claim/line. | Exact duplicate claim/service |
| CDXAGE | 9 | Diagnosis inconsistent with patients age | The diagnosis is inconsistent with the patient's age. |
| CDXGDR | 10 | Diagnosis invalid for gender | The diagnosis is inconsistent with the patient's gender. |
| CDXIN | M81 | Diagnosis Code(s) inappropriately coded (mutually exclusive codes/diagnosis, laterality, modifier mismatch). | You are required to code to the highest level of specificity. |
| CDXPU | N362 | Procedure units billed exceed the maximum allowed units for this code. | The number of Days or Units of Service exceeds our acceptable maximum. |
| CEEG | N432 | Ambulatory EEG without Resting EEG | Adjustment based on a Recovery Audit. |
| CEMLOS | N22 | E/M Service Inappropriately Coded | This procedure code was added/changed because it more accurately describes the services rendered. |
| CEMRC | N22 | E&M level recoded. | This procedure code was added/changed because it more accurately describes the services rendered. |

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|---|---|---|---|
| CEMSIP | N22 | E/M Service Inappropriately Coded | This procedure code was added/changed because it more accurately describes the services rendered. |
| CEXCL | 151 | Exceeds Clinical guidelines frequency limitation. | Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. |
| CEXPPT | 13 | Patient Previously Reported As Expired | The date of death precedes the date of service. |
| CGCODE | M51 | Procedure invalid for Medicare purposes. Medicare uses another code for reporting of these services. | Missing/incomplete/invalid procedure code(s). |
| CGLBPD | M86 | Global Service previously paid to the Facility | Service denied because payment already made for same/similar procedure within set time frame. |
| CGLOB | M86 | Global Service previously paid | Service denied because payment already made for same/similar procedure within set time frame. |
| CICD | M81 | Diagnosis code is not coded to the highest level of specificity. | You are required to code to the highest level of specificity. |
| CICDSP | M81 | Principal diagnosis inappropriately coded based upon ICD-10 coding guidelines (Manifestation/Sequela code). | You are required to code to the highest level of specificity. |
| CIIPMS | 97 | Included In Physical Medicine Service | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CIMLP | 107 | Implant procedure requires Implant device. | The related or qualifying claim/service was not identified on this claim |
| CINCOC | 97 | Included as part of another procedure. | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CINCTO | 97 | "Incident to" service denial | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CINMOD | 4 | Invalid Modifier Code Submitted | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CINMR | N20 | Include in Monthly Rental Fee | Service not payable with other service rendered on the same date. |
| CINPP | N20 | Included in the CPT definition or nature of the primary procedure. | Service not payable with other service rendered on the same date. |
| CINREV | M50 | Invalid Revenue Code | Missing/incomplete/invalid revenue code(s). |

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| CINVCD | B8 | Invalid CPT/HCPCS/Rev code for DOS | Alternative services were available, and should have been utilized. |
| CIPOS | 58 | Place of service not appropriate for procedure. | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |
| CIPPD | N432 | Multiple providers Billing Inpatient Hospital Per Diem codes (Cotiviti) | Adjustment based on a Recovery Audit. |
| CIPPRO | 58 | Inpatient Procedure | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |
| CIPT | N432 | CIPT-Acute Inpatient Transfers | Adjustment based on a Recovery Audit. |
| CLABEX | 97 | Price of Lab Panel Components Exceed Lab Panel Price | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CLCOS | B8 | Recoded to the least costly alternative. | Alternative services were available, and should have been utilized. |
| CLTDX | 11 | Clinical Research Studies Require Appropriate Diagnosis | The diagnosis is inconsistent with the procedure. |
| CM50 | 4 | Modifier 50 inappropriate for terminated procedure. | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CMECCI | N20 | Mutually exclusive procedure not allowed by NCCI. | Service not payable with other service rendered on the same date. |
| CMEDNS | 50 | Services Not Considered Medically Necessary | These are non-covered services because this is not deemed a 'medical necessity' by the payer. |
| CMEND | 59 | Multiple Endoscopy review | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CMENDO | 59 | Multiple Endoscopy payment methodology | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CMENLM | 122 | Outpatient Mental Health Treatment Limitation Applied | Psychiatric reduction. |
| CMMOD | 4 | Invalid/Missing modifier | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CMOD | 4 | Invalid Modifier code submitted. | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CMODBD | 4 | Invalid Modifier Code Submitted | The procedure code is inconsistent with the modifier used or a required modifier is missing. |

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|---|---|---|---|
| CMODC | 4 | Modifier correction | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CMODCA | 4 | Use of modifier CA with more than one procedure not allowed | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CMODEV | - | Modifier Denotes Full or Partial Device Credit | - |
| CMODPR | 4 | Modifier Inappropriate For Provider Type | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CMODPS | 4 | Modifier inappropriate for Place of Service | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CMODR | - | Modifiers re-ordered. | - |
| CMODRE | 59 | Modifier payment adjustment. | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CMPPR | 59 | Multiple procedure reduction. | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CMPRCV | 59 | Multiple Procedure Reduction for Cardiovascular Services | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CMPROP | 59 | Multiple Procedure Reduction for Ophthalmology Services | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CMSN | 96 | Medicare Status N Codes | Non-covered charges. |
| CMULNM | 59 | Multiple Nuclear Medicine Studies | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CNCCOS | 54 | Co-surgeon not covered/not allowed for this procedure. | Multiple physicians/assistants are not covered in this case |
| CNCDX | 11 | Service non-covered with the diagnosis. | The diagnosis is inconsistent with the procedure. |
| CNDCHC | M119 | NDC Inappropriate for HCPCS code | Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). |
| CNDCIN | M119 | NDC Invalid | Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). |

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|---|---|---|---|
| CNDCMI | M119 | CNDCMI-Submit description of drug with NDC number | Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). |
| CNE | 172 | CNE- Claim Not Encounter | Payment is adjusted when performed/billed by a provider of this specialty. |
| CNEWPT | B16 | Replace New Patient with Established | 'New Patient' qualifications were not met. |
| CNOAST | 54 | Assistant surgeon not warranted. | Multiple physicians/assistants are not covered in this case |
| CNOCHG | - | No Change Recommended | - |
| CNPPFS | 171 | CNPPFS-Drug tests not payable to physicians. | Payment is denied when performed/billed by this type of provider in this type of facility |
| CNPRF | 58 | Not appropriate for Professional billing. Code designated by CMS for Outpatient Hospital billing. | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |
| CNPTOB | 96 | Bill Type Not Payable. | Non-covered charges. |
| CNSEP | B15 | Separate procedures not payable. | This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. |
| CNSPOS | 171 | Not covered when performed by this provider in this place of service. | Payment is denied when performed/billed by this type of provider in this type of facility |
| CNTSAF | 50 | Services Not Considered Medically Necessary | These are non-covered services because this is not deemed a 'medical necessity' by the payer. |
| COB | 23 | COB-COB-Overpayment Adjustment | The impact of prior payer(s) adjudication including payments and/or adjustments. |
| CON | 172 | CON-Provider Contract Selection correction | Payment is adjusted when performed/billed by a provider of this specialty. |
| CONNC | 202 | Convenience item not covered. | Non-covered personal comfort or convenience services. |
| CONTR | B10 | Ionic contrast media reduction | Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test. |
| COP3IP | M86 | COP3IP-Outpatient Charges Billed Before or During an Inpatient Admission | Service denied because payment already made for same/similar procedure within set time frame. |
| COSSP | 54 | Co-Surgeons Cannot Be Same Subspecialty | Multiple physicians/assistants are not covered in this case |
| COSUR | 172 | COSUR-Payment for Co-Surgeon and Team Surgery error | Payment is adjusted when performed/billed by a provider of this specialty. |

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|---|---|---|---|
| CPARUN | 151 | CPT/HCPCS Code May Not Be Billed With Partial Units | Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. |
| CPAYAI | 107 | Payable only with active intervention. | The related or qualifying claim/service was not identified on this claim |
| CPCNC | 96 | Procedure Code Not Covered | Non-covered charges. |
| CPCODG | N22 | Inappropriate coding based on Procedure Coding guidelines. | This procedure code was added/changed because it more accurately describes the services rendered. |
| CPCPOS | 5 | Professional Component Not Payable For This Place Of Service | The procedure code/bill type is inconsistent with the place of service |
| CPDXIN | MA63 | Missing/Incomplete or Invalid principal diagnosis code. | Missing/incomplete/invalid principal diagnosis. |
| CPEXFP | MA47 | Provider Excluded from Federally Funded Programs | Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. |
| CPGCD | N432 | Lab/Rad/Other Diagnostic Paying greater than charged. (Cotiviti) | Adjustment based on a Recovery Audit. |
| CPHNID | M44 | Partial hospitalization condition code 41 not approved for type of bill | Missing/incomplete/invalid condition code. |
| CPIEMS | N19 | Rebundled service - included in E&M service | Procedure code incidental to primary procedure. |
| CPINMC | 256 | Services Non Covered by Medicare Guidelines | Service not payable per managed care contract. |
| CPIPA | 6 | Procedure Invalid for patients age. | The procedure/revenue code is inconsistent with the patient's age. |
| CPOSC | M77 | Place of Service correction | Missing/incomplete/invalid/inappropriate place of service. |
| CPOVPT | N432 | Prior Overpayment Detection | Adjustment based on a Recovery Audit. |
| CPPGC | N432 | Professional claim paying greater than charged. | Adjustment based on a Recovery Audit. |
| CPPV | M144 | PreOp/PostOp visit included in Global Surgical package. | Pre-/post-operative care payment is included in the allowance for the surgery/procedure. |
| CPRAGE | 6 | Procedure recoded based on patients age. | The procedure/revenue code is inconsistent with the patient's age. |
| CPRMOD | 4 | Procedure denied or modified; inconsistent with submitted modifier or missing required modifier. | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CPROC | N22 | Procedure Code correction | This procedure code was added/changed because it more accurately describes the services rendered. |

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| CPROIC | N22 | Procedure inappropriately coded. | This procedure code was added/changed because it more accurately describes the services rendered. |
| CPSFAC | 171 | Professional Service Not Payable To The Facility Provider | Payment is denied when performed/billed by this type of provider in this type of facility |
| CPSPIN | 172 | Provider Specialty invalid for this type of service. | Payment is denied when performed/billed by this type of provider in this type of facility |
| CPTIN | N56 | Invalid CPT/HCPCS/Rev code for DOS | Procedure code billed is not correct/valid for the services billed or the date of service billed. |
| CQUSVC | 256 | Questionable covered service | Service not payable per managed care contract. |
| CRADRE | 59 | Multiple Procedure Reduction for Radiology | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| CRADTX | N19 | Included in Radiation Treatment Management service. | Procedure code incidental to primary procedure. |
| CRCBT | M50 | Revenue Code does not match Bill Type. | Missing/incomplete/invalid revenue code(s). |
| CREB | N19 | Rebundled service | Procedure code incidental to primary procedure. |
| CREBVI | N19 | Rebundled - Visit | Procedure code incidental to primary procedure. |
| CRECOD | N22 | Recoded to more accurately describe the services rendered. | This procedure code was added/changed because it more accurately describes the services rendered. |
| CRECOH | N22 | HCPCS Recoded Per Health Plan Policy | This procedure code was added/changed because it more accurately describes the services rendered. |
| CRELS | 107 | Related or Qualifying service on same date of service not paid. | The related or qualifying claim/service was not identified on this claim |
| CRETOR | 97 | Return To OR Payment Adjustment | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CREVCD | M50 | Revenue Code inappropriately coded. | Missing/incomplete/invalid revenue code(s). |
| CREVHC | M20 | Revenue Code requires HCPCS code. | Missing/incomplete/invalid HCPCS. |
| CREVMC | M50 | Revenue Code Not Recognized by Medicare | Missing/incomplete/invalid revenue code(s). |
| CSCREM | 97 | CSCREM-Screening service is included in the E&M payment | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CSDPID | 188 | Service Denied Because Of Potential Interaction With Another Drug Administered Recently | This product/procedure is only covered when used according to FDA recommendations. |

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| CSDX | M76 | Secondary diagnosis missing or invalid. | Missing/incomplete/invalid diagnosis or condition. |
| CSEPMC | B15 | Separate payment for services is not provided by Medicare | This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. |
| CSIGD | 7 | Service invalid for gender | The procedure/revenue code is inconsistent with the patient's gender. |
| CSOSD | - | Site of Service payment differential | - |
| CSPLIT | B20 | Payment includes Pre- and Intra-Operative care. | Procedure/service was partially or fully furnished by another provider. |
| CSPPPD | B13 | Service previously processed/paid; same/different provider. | Previously paid. Payment for this claim/service may have been provided in a previous payment. |
| CSRGD | 7 | Service recoded based on gender. | The procedure/revenue code is inconsistent with the patient's gender. |
| CSSAS | 54 | Same surgeon billing for Surgery/Assistant Surgeon. | Multiple physicians/assistants are not covered in this case |
| CSSS | M86 | Same/similar service performed recently for the same condition. | Service denied because payment already made for same/similar procedure within set time frame. |
| CSUPP | 16 | Resubmit with supporting documentation (procedure description, operative notes, etc.). | Claim/service lacks information which is needed for adjudication. |
| CTCCAP | - | OPPS Technical Cap Applied | - |
| CTCD | 11 | CTCD-Non-Covered dx for Transcranial Doppler (TCD) per LCD L33627 | The diagnosis is inconsistent with the procedure. |
| CTCPOS | M97 | Technical service invalid for Place of Service submitted. | Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the |
| CTMSNC | 4 | Team Surgeon not covered/not allowed. | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| CTPCBB | 115 | Terminated bilateral procedure or terminated procedure with units greater than 1 | Procedure postponed, canceled, or delayed. |
| CTPSIC | N22 | ReplaceGlob/TechComp | This procedure code was added/changed because it more accurately describes the services rendered. |
| CTXFQ | M86 | Only one service allowed per course of treatment | Service denied because payment already made for same/similar procedure within set time frame. |

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| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| CVENI | 97 | Blood Collection Included In Lab Services | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| CVMR | 16 | CVMR-Requested Medical Records Not Received | Claim/service lacks information which is needed for adjudication. |
| CVRP | 216 | CVRP-Clinical Chart Validation–DRG Reprice | Based on the findings of a review organization |
| CVTD | 50 | CVTD-Vitamin D testing is not considered medically necessary with the diagnosis(es) reported. | These are non-covered services because this is not deemed a "medical necessity" by the payer. |
| CXGA | N22 | Crosswalk Surgical code to General Anesthesia code. | This procedure code was added/changed because it more accurately describes the services rendered. |
| CXPIN | 55 | Non-covered Experimental/Investigational procedure. | Procedure/treatment/drug is deemed experimental/investigational by the payer |
| D01 | 21 | D01-Auto- No fault related | This injury/illness is the liability of the no-fault carrier. |
| D02 | 42 | D02-Maximum benefits paid | |
| D03 | 19 | D03-Work related injury | This is a work-related injury/illness and thus the liability of the Worker's Compensation Cariier. |
| D04 | 141 | D04-Benefit not available on date of service | Claim spans eligible and ineligible periods of coverage. |
| D05 | 6 | D05-Age restricted benefit | The procedure/revenue code is inconsistent with the patient's age. |
| D06 | 16 | D06-Invalid/missing admission date | Claim/service lacks information which is needed for adjudication. |
| D07 | 97 | D07-After Care Period | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| D08 | B18 | D08-Invalid CPT/HCPCS/Rev code for DOS | |
| D09 | 54 | D09-Assistant Surgeon Not Covered | Multiple physicians/assistants are not covered in this case. |
| D10 | 16 | D10-Patient status invalid for bill type | Claim/service lacks information which is needed for adjudication. |
| D100 | 125 | Discontinued Bill Type | Submission/billing error(s). |
| D101 | D18 | D101-Primary Diagnosis Required | |
| D102 | 16 | D102-Resubmit the claim with the required Value Code 24 and Medicaid Rate Code. | Claim/service lacks information which is needed for adjudication. |
| D103 | 16 | D103-Invalid Clinic CPT code - Eff. 1/1/14, OPD Clinic visits should be billed with HCPCS code G0463. | Claim/service lacks information which is needed for adjudication. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| D104 | 109 | D104-Resubmit claim directly to HealthFirst. | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| D105 | 16 | D105-Same Surgeon billing for Surgery/Assistant Surgery. Resubmit claim with Assistant Surgeon name/credentials. | Claim/service lacks information which is needed for adjudication. |
| D106 | 45 | D106-Pending Anthem Facility Pricing | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| D107 | 109 | D107 - Bill Logisticare. Questions? Call (866) 913- 4340 | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| D108 | A1 | D108-Deny CA Screening in females <21 with screening dx only (USPSTF) | Claim/service denied. |
| D109 | A1 | D109-Deny CA screening in females 21 and older with screening dx only; any other screening service reported in the previous 13 months (USPSTF) | Claim/service denied. |
| D11 | 97 | D11-Rebundled service | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| D110 | A1 | D110-Deny CA screening in females 21 and older with screening dx only; any other screening service reported in the previous 3 years (USPSTF) | Claim/service denied. |
| D111 | A1 | D111-Deny HPV testing in females <30 with a screening dx only. (USPSTF) | Claim/service denied. |
| D112 | A1 | D112-Deny HPV testing in females 30 - 65 when performed >1x in 5 years with a screening dx only. (USPSTF) | Claim/service denied. |
| D113 | A1 | D113-Deny routine serologic screening (86696) in patients 13 and older with a screening dx only. (USPSTF) | Claim/service denied. |
| D114 | M49 | D114-Missing Value Code 85 and FIPS State/County code | Missing/incomplete/invalid value code(s) or amount(s). |
| D115 | 147 | D115-Emblem Unpriced Non-par provider, resending for pricing review | Provider contracted/negotiated rate expired or not on file. |
| D12 | 18 | D12-Duplicate line on the same claim | Duplicate claim/service. |
| D13 | 16 | D13-Invalid HCPCS for Revenue | Claim/service lacks information which is needed for adjudication. |
| D14 | 16 | D14-Insufficient units for date span | Claim/service lacks information which is needed for adjudication. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| D15 | 58 | D15-Invalid/Missing Place of Service | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |
| D16 | D19 | D16-Submit medical records | |
| D17 | 38 | D17-Referral Required | Services not provided or authorized by designated (netowrk/primary care) providers. |
| D18 | 109 | D18-SSI- Bill Medicaid (UBA) | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| D19 | 62 | D19-Unauthorized days not paid | |
| D20 | 109 | D20-Aetna self-insured | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| D21 | 109 | D21-Not CMO bill insurer. | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| D22 | 96 | D22-MH - Inpatient Rehab Not Covered | Non-covered charges. |
| D23 | 29 | D23-Timely filing exceeded | The time limit for filing has expired. |
| D24 | 39 | D24-Authorization denied | Services denied at the time authorization/pre-certification was requested. |
| D25 | 147 | D25-EHIP Pricing Error | Provider contracted/negotiated rate expired or not on file. |
| D26 | D19 | D26-Procedure description needed | |
| D27 | 16 | D27-Attending physician required | Claim/service lacks information which is needed for adjudication. |
| D28 | 16 | D28-Discharge status required for inpatient/SNF claims | Claim/service lacks information which is needed for adjudication. |
| D29 | 18 | D29-Duplicate of previously paid claim | Duplicate claim/service. |
| D30 | 50 | D30-Non Covered Contraceptives | These are non-covered services because this is not deemed a "medical necessity" by the payer. |
| D31 | 16 | D31-Missing discharge hour | Claim/service lacks information which is needed for adjudication. |
| D32 | 78 | D32-Covered days do not match accomodation days | Non-covered days/Room charge adjustment. |
| D33 | 149 | D33-Individual lifetime benefit amount exceeded | Lifetime benefit maximum has been reached for this service/benefit category. |
| D34 | 149 | D34-Family lifetime unit limit exceeded | Lifetime benefit maximum has been reached for this service/benefit category. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| D35 | 149 | D35-Family annual limit exceeded | Lifetime benefit maximum has been reached for this service/benefit category. |
| D36 | 149 | D36-Individual lifetime visit limit exceeded | Lifetime benefit maximum has been reached for this service/benefit category. |
| D37 | 149 | D37-Individual benefit limit exceeded | Lifetime benefit maximum has been reached for this service/benefit category. |
| D38 | 16 | D38-Individual DOS required | Claim/service lacks information which is needed for adjudication. |
| D39 | 16 | D39-Incomplete claim | Claim/service lacks information which is needed for adjudication. |
| D40 | 96 | D40-Medicare non covered DME | Non-covered charges. |
| D41 | 96 | D41-Reporting only, no payment. | Non-covered charges. |
| D42 | 16 | D42-Invalid Type of Service | Claim/service lacks information which is needed for adjudication. |
| D43 | A8 | D43-Invalid/missing DRG | Ungroupable DRG. |
| D44 | 58 | D44-Invalid POS for benefit | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |
| D45 | 96 | D45-Non-covered benefit | Non-covered charges. |
| D46 | B7 | D46-Provider on pay hold | This provider was not certified/eligible to be paid for this procedure/service on this date of service. |
| D47 | 96 | D47-SNF Not Covered | Non-covered charges. |
| D48 | 96 | D48-PT/OT/ST Not Covered | Non-covered charges. |
| D49 | 96 | D49-MH Services Not Covered | Non-covered charges. |
| D50 | 27 | D50-IPA termed contract | Expenses incurred after coverage terminated. |
| D51 | 38 | D51-Prior authorization required | Services not provided or authorized by designated (netowrk/primary care) providers. |
| D52 | B9 | D52-Non Covered Hospice Services | Patient is enrolled in a Hospice. |
| D53 | 109 | D53-Non IPA - Bill Health Plan | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| D54 | 24 | D54-Capitated Coverage | Charges are covered under a capitation agrement/managed care plan. |
| D55 | 40 | D55-Emergency Requirements Not Met | Charges do not meet qualifications for emergent/urgent care. |
| D56 | 172 | D56-PCP Benefit | Payment is adjusted when performed/billed by a provider of this specialty. |
| D57 | 96 | D57-HHC Not Covered | Non-covered charges. |
| D58 | 96 | D58-Non Covered Cosmetic Procedure | Non-covered charges. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| D59 | 55 | D59-Non Covered Experimental Procedures | Procedure/treatment is deemed experimental/investigational by the payer. |
| D60 | B7 | D60-Incorrect Billing Tin | This provider was not certified/eligible to be paid for this procedure/service on this date of service. |
| D61 | 109 | D61 - DOS prior to Contract Effective date | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| D62 | 96 | D62- Non Covered By Medicaid | Non-covered charges. |
| D63 | B8 | D63- Payable under the Vaccines for Children's Program | Alternative services were available, and should have been utilized. |
| D64 | 8 | D64-Specialty Not Certified for Imaging Services | The procedure code is inconsistent with the provider type/specialty (taxonomy). |
| D65 | 109 | D65- DOS after Contract Termination Date | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| D66 | 97 | D66-Behavioral Health Rebundle | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| D67 | 4 | D67-Invalid/Missing Required Modifier | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| D68 | 119 | D68-Maximum Units Exceeded | Benefit maximum for this time period or occurrence has been reached. |
| D81 | 62 | D81-Prior authorization has insufficient units remaining. | |
| D85 | 11 | D85-Service non covered with the diagnosis | The diagnosis is inconsistent with the procedure. |
| D86 | 54 | D86-Team Surgeon not covered | Multiple physicians/assistants are not covered in this case. |
| D87 | 54 | D87-Co-Surgeon not Covered | Multiple physicians/assistants are not covered in this case. |
| D88 | 16 | D88-Invalid/Missing Condition Code | Claim/service lacks information which is needed for adjudication. |
| D89 | 16 | D89-Invalid/Missing Occurence Code | Claim/service lacks information which is needed for adjudication. |
| D90 | 109 | D90-Hospice submit MCR EOB | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| D91 | 38 | D91-UBA Out Of Network Provider | Services not provided or authorized by designated (netowrk/primary care) providers. |
| D92 | 109 | Claim received and sent to Beacon Health Options for processing | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| D93 | 96 | D93-FHP Non-covered DME/Supplies. | Non-covered charges. |
| D94 | A1 | D94-Inpatient coverage by Geriatrics | Claim/service denied. |
| D95 | A1 | D95-Part of MCD Reclamation project | Claim/service denied. |
| D96 | 16 | D96-We cannot process an unlisted behavioral care code. Please resubmit with a valid behavioral care procedure code. | Claim/service lacks information which is needed for adjudication. |
| D97 | N34 | D97-Please resubmit claim on a CMS-1450 (UB-04) form. | Incorrect claim form/format for this service. |
| D98 | 16 | D98-APG claims should not be billed with date ranges. Please submit each date of service as a separate claim. | Claim/service lacks information which is needed for adjudication. |
| D99 | 16 | D-99 Medicaid Elective OB Procedure- Non Covered Service. Resubmit with Valid Dx and Modifier | Claim/service lacks information which is needed for adjudication. |
| DACP01 | 16 | DACP01-No Available APC/Fee Schedule Rate Record | Claim/service lacks information which is needed for adjudication. |
| DACP02 | M20 | DACP02-Invalid HCPCS Code | Missing/incomplete/invalid HCPCS. |
| DACP03 | 16 | DACP03-Invalid payment Status | Claim/service lacks information which is needed for adjudication. |
| DACP04 | 96 | DACP04-Not Covered or Not Covered Under OPPS | Non-covered charges. |
| DACP07 | 16 | DACP07-Co-Payment Out of Valid Range | Claim/service lacks information which is needed for adjudication. |
| DACP08 | 4 | DACP08-Invalid Modifier for Pricing | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DAE | B1 | DAE-UBA Authorized units exceeded | Non-covered visits. |
| DAH | 16 | DAH-Missing admission hour | Claim/service lacks information which is needed for adjudication. |
| DAN | 125 | DAN-Resubmit with Anesthesia CPT | Submission/billing error(s). |
| DAP100 | 16 | DAP100-Claim for HSCT Allogenic transplantation lacks required Rev Code line for Donor Acquisition services | Claim/service lacks information which is needed for adjudication. |
| DAP101 | 4 | DAP101-Item or service with modifier PN not allowed under PFS | The procedure code is inconsistent with the modifier used or a required modifier is missing. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DAP102 | 4 | DAP102-Modifiers PO/PN not allowed on the same line | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DAP103 | 182 | DAP103-Modifiers reported prior to FDA approval date | Procedure modifier was invalid on the date of service. |
| DAPC1 | 146 | DAPC-1- Invalid diagnosis code | Diagnosis was invalid for the date(s) of service reported. |
| DAPC10 | A1 | DAPC-10- Service submitted for denial (condition code 21) | Claim/service denied. |
| DAPC11 | 147 | DAPC-11- Service submitted for FI/MAC review (condition code 20) | Provider contracted/negotiated rate expired or not on file. |
| DAPC12 | 96 | DAPC-12- Questionable covered service | Non-covered charges. |
| DAPC13 | 97 | DAPC13- Separate payment for services not provided by Medicare | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPC15 | A1 | DAPC-15- Service unit out of range for procedure | Claim/service denied. |
| DAPC17 | A1 | DAPC-17- Inappropriate specification of bilateral procedure | Claim/service denied. |
| DAPC18 | 58 | DAPC-18- Inpatient procedure | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |
| DAPC19 | 97 | DAPC-19- Mutually exclusive procedure that is not allowed by NCCI even if appropriate modifier is present | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPC2 | 9 | DAPC-2- Diagnosis and age conflict | The diagnosis is inconsistent with the patient's age. |
| DAPC20 | 96 | DAPC-20- Code 2 of a code pair that is not allowed by NCCI even if appropriate modifier | Non-covered charges. |
| DAPC21 | A1 | DAPC-21- Medical visit on same day as a type “T” or “S” procedure without modifier 25 | Claim/service denied. |
| DAPC22 | 4 | DAPC-22- Invalid modifier | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DAPC23 | 16 | DAPC-23- Invalid Date | Claim/service lacks information which is needed for adjudication. |
| DAPC24 | 16 | DAPC-24- Date out of OCE range | Claim/service lacks information which is needed for adjudication. |
| DAPC25 | 6 | DAPC-25- Invalid age | The procedure/revenue code is inconsistent with the patient's age. |
| DAPC26 | 7 | DAPC-26- Invalid sex | The procedure/revenue code is inconsistent with the patient's gender. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DAPC27 | 97 | DAPC-27- Only incidental services reported | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPC28 | 96 | DAPC-28- Code not recognized by Medicare for outpatient claims; alternate code for same service may be available | Non-covered charges. |
| DAPC29 | 11 | DAPC-29- Partial hospitalization service for non-mental health diagnosis | The diagnosis is inconsistent with the procedure. |
| DAPC3 | 10 | DAPC-3- Diagnosis and sex conflict | The diagnosis is inconsistent with the patient's gender. |
| DAPC30 | 96 | DAPC-30- Insufficient services on day of partial hospitalization | Non-covered charges. |
| DAPC32 | 96 | DAPC-32- Partial hospitalization claim spans 3 or less days with insufficient services on at least one of the days | Non-covered charges. |
| DAPC33 | 96 | DAPC-33- Partial hospitalization claim spans more than 3 days with insufficient number of days meeting PHP services | Non-covered charges. |
| DAPC34 | 96 | DAPC-34- Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria | Non-covered charges. |
| DAPC35 | 16 | DAPC-35- Only mental health education and training services provided | Claim/service lacks information which is needed for adjudication. |
| DAPC37 | 119 | DAPC-37- Terminated bilateral procedure or terminated procedure with units greater than 1 | Benefit maximum for this time period or occurrence has been reached. |
| DAPC38 | 150 | DAPC-38- Inconsistency between implanted device or administered substance and implantation or associated procedure | Payer deems the information submitted does not support this level of service. |
| DAPC39 | 4 | DAPC-39- Mutually exclusive procedure that would be allowed by NCCI if appropriate modifier were present | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DAPC40 | 4 | DAPC-40- Code 2 of a code pair that would be allowed by NCCI if appropriate modifier were present | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DAPC41 | 16 | DAPC-41- Invalid revenue code | Claim/service lacks information which is needed for adjudication. |
| DAPC42 | 119 | DAPC-42- Multiple medical visits on same day with same revenue code without condition code G0 | Benefit maximum for this time period or occurrence has been reached. |
| DAPC43 | 16 | DAPC-43- Transfusion or blood product exchange without specification of blood | Claim/service lacks information which is needed for adjudication. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DAPC44 | 199 | DAPC-44- Observation revenue code on line item with non-observation HCPCS code | Revenue code and procedure code do not match. |
| DAPC45 | 97 | DAPC-45- Inpatient separate procedures not paid | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPC46 | 5 | DAPC-46- Partial hospitalization condition code 41 not approved for type of bill | The procedure code/bill type is inconsistent with the place of service. |
| DAPC47 | 97 | DAPC-47- Service is not separately payable | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPC48 | 199 | DAPC-48-Revenue center requires HCPCS | Revenue code and procedure code do not match. |
| DAPC49 | 97 | DAPC-49- Service on same day as inpatient procedure | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPC5 | 167 | DAPC-5- E-code cannot be used as principal diagnosis | This (these) diagnosis(es) is (are) not covered. |
| DAPC50 | 96 | DAPC-50- Non-covered under any Medicare outpatient benefit, based on statutory exclusion | Non-covered charges. |
| DAPC53 | A1 | DAPC-53- Codes G0378 and G0379 only | Claim/service denied. |
| DAPC55 | 96 | DAPC-55- Non-reportable for site of service | Non-covered charges. |
| DAPC57 | A1 | DAPC-57- Composite E/M condition not met | Claim/service denied. |
| DAPC58 | A1 | DAPC-58- G0379 only allowed with G0378 | Claim/service denied. |
| DAPC59 | 167 | DAPC-59- Clinical trial requires diagnosis code V707 as other than primary diagnosis | This (these) diagnosis(es) is (are) not covered. |
| DAPC6 | 16 | DAPC-6- DAPC-6- Invalid procedure code | Claim/service lacks information which is needed for adjudication. |
| DAPC60 | 4 | DAPC-60- Use of modifier CA with more than one procedure not allowed | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DAPC61 | 109 | DAPC-61- Service can only be billed to the DMERC | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DAPC62 | 96 | DAPC-62- Code not recognized by OPPS; alternate code for same service may be available | Non-covered charges. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DAPC63 | 97 | DAPC-63- OT (Occupational Therapy) code only billed on partial hospitalization claims | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPC64 | 97 | DAPC-64- AT (activity therapy) service not payable outside the partial hospitalization program | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPC65 | 96 | DAPC-65- Revenue code not recognized by Medicare | Non-covered charges. |
| DAPC66 | 147 | DAPC-66- Code requires manual pricing | Provider contracted/negotiated rate expired or not on file. |
| DAPC67 | 114 | DAPC-67- Service provided prior to FDA approval | Procedure/product not approved by the Food and Drug Administration. |
| DAPC68 | 96 | DAPC-68- Service provided prior to date of National Coverage Determination | Non-covered charges. |
| DAPC69 | 15 | DAPC-69- Service provided outside approval period | The authorization number is missing, invalid, or does not apply to the billed services or provider. |
| DAPC70 | 16 | DAPC-70- CA modifier requires patient status code 20 | Claim/service lacks information which is needed for adjudication. |
| DAPC71 | 16 | DAPC-71- Claim lacks required device code | Claim/service lacks information which is needed for adjudication. |
| DAPC72 | 109 | DAPC-72- Service not billable to the Fiscal Intermediary/MAC | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DAPC73 | 16 | DAPC-73- Incorrect billing of blood and blood products | Claim/service lacks information which is needed for adjudication. |
| DAPC74 | 4 | DAPC-74- Units greater than one for bilateral procedure billed with modifier 50 | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DAPC75 | 4 | DAPC-75- Incorrect billing of modifier FB or FC | The procedure code is inconsistent with the modifier used or a required modifier is |
| DAPC76 | A1 | DAPC-76- Trauma response critical care code without revenue code 068X and CPT | Claim/service denied. |
| DAPC77 | 16 | DAPC-77- Claim lacks allowed procedure code | Claim/service lacks information which is needed for adjudication. |
| DAPC78 | 16 | DAPC-78- Claim lacks required radiolabeled product | Claim/service lacks information which is needed for adjudication. |
| DAPC79 | 199 | DAPC-79- Incorrect billing of revenue code with HCPCS code | Revenue code and procedure code do not match. |
| DAPC8 | 7 | DAPC8- Procedure and sex conflict | The procedure/revenue code is inconsistent with the patient's gender. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DAPC80 | 97 | DAPC80- Mental health code not approved for partial hospitalization program | The benefit for this service is included in the payment/allowance for another |
| DAPC81 | 96 | DAPC81- Mental health service not payable outside the partial hospitalization program | Non-covered charges. |
| DAPC82 | 16 | DAPC82- Charge exceeds token charge ($1.01) | Claim/service lacks information which is needed for adjudication. |
| DAPC83 | 96 | DAPC83- Service provided on or after effective date of NCD non-coverage | Non-covered charges. |
| DAPC84 | 16 | DAPC84-Claim Lacks Required Primary Code | Claim/service lacks information which is needed for adjudication. |
| DAPC85 | 16 | DAPC85-Claim Lacks Required Device Code or Required Procedure Code | Claim/service lacks information which is needed for adjudication. |
| DAPC86 | 16 | DAPC86-Manifestation Code Not Allowed as Principal Diagnosis Code | Claim/service lacks information which is needed for adjudication. |
| DAPC87 | 16 | DAPC87-Skin substitute application procedure without appropriate skin substitute product code | Claim/service lacks information which is needed for adjudication. |
| DAPC88 | 16 | DAPC88-FQHC payment code not reported for FQHC claim | Claim/service lacks information which is needed for adjudication. |
| DAPC89 | 16 | DPAC89-FQHC claim lacks required qualifying visit code | Claim/service lacks information which is needed for adjudication. |
| DAPC-9 | 96 | DAPC9-NON-COVERED UNDER ANY MEDICARE OUTPATIENT BENEFIT, FOR REASONS OTHER THAN STATUTORY EXCLUSION | Non-covered charges. |
| DAPC90 | 16 | DAPC90-Incorrect Rev Code reported for FQHC payment code | Claim/service lacks information which is needed for adjudication. |
| DAPC91 | 16 | DAPC91-Item or service not covered under FQHC PPS | Claim/service lacks information which is needed for adjudication. |
| DAPC92 | 16 | DAPC92-Device-dependent procedure code lacks required device code | Claim/service lacks information which is needed for adjudication. |
| DAPC93 | 16 | DAPC93-Corneal tissue processing reported without cornea transplant procedure | Claim/service lacks information which is needed for adjudication. |
| DAPC94 | 16 | DAPC94-Biosimilar HCPCS reported without biosimilar modifier | Claim/service lacks information which is needed for adjudication. |
| DAPC95 | 16 | DAPC95-Weekly Partial Hospitalization services require minimim of 20 hours of service as evidenced in the PHP plan of care | Claim/service lacks information which is needed for adjudication. |
| DAPC98 | 16 | DAPC98-Claim with pass through device lacks required procedure | Claim/service lacks information which is needed for adjudication. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DAPC99 | 16 | DAPC99-Claim with pass through or non pass through drug or biological lacks OPPS payable procedure | Claim/service lacks information which is needed for adjudication. |
| DAPG01 | 16 | DAPG01-No Claim Lines Submitted | Claim/service lacks information which is needed for adjudication. |
| DAPG02 | 16 | DAPG02-No Principal Diagnosis Has Been Submitted | Claim/service lacks information which is needed for adjudication. |
| DAPG03 | 16 | DAPG03-Invalid or Inconsistent From/Thru or Service Dates | Claim/service lacks information which is needed for adjudication. |
| DAPG12 | 16 | Missing Rate Code | Claim/service lacks information which is needed for adjudication. |
| DAPP02 | 95 | Visit Consists of All Never Pay or Stand Alone events | Non-covered charges. |
| DAPP03 | 96 | Service is Never Pay | Non-covered charges. |
| DAPP04 | 58 | Invalid Ambulatory Surgical Center Claim; Procedure not on list. | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |
| DAPP05 | 96 | Carve-Out Service not paid under APG | Non-covered charges. |
| DAPP06 | 16 | Missing or Invalid Fee Schedule Type | Claim/service lacks information which is needed for adjudication. |
| DAPP08 | 4 | Invalid Modifier Pair submitted | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DAPP09 | 97 | Packaged Service | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPP10 | 97 | Line Item Rejection from Editor; NCCI edit | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPP11 | 96 | No Payment per APG Ancillary Policy | Non-covered charges. |
| DAPP12 | 59 | Payment Reduction Per APG Ancillary Policy | Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) |
| DAPP13 | 16 | Invalid Rate Code | Claim/service lacks information which is needed for adjudication. |
| DAPP14 | 16 | Invalid Observation Billing | Claim/service lacks information which is needed for adjudication. |
| DAPP15 | 16 | Telehealth Facility Fee Invalid | Claim/service lacks information which is needed for adjudication. |
| DAPP16 | 96 | Never Event | Non-covered charges. |
| DAPP17 | 58 | Invalid Billing of Offsite Services | Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DAPP18 | 11 | Diagnosis and Procedure Code Conflict | The diagnosis is inconsistent with the procedure. |
| DAPP19 | 4 | Missing or Invalid Modifier for Pricing | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DAPP20 | 97 | Consolidated Service | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPP22 | 96 | Denial Claim | Non-covered charges. |
| DAPP23 | 16 | Invalid Service Date, From-Thru Dates, or Admission Date | Claim/service lacks information which is needed for adjudication. |
| DAPP25 | M119 | Improper Billing of Drugs | Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). |
| DAPP29 | 96 | Non-Covered Service | Non-covered charges. |
| DAPP30 | 151 | Service Exceeded Maximum Number of Allowed Units | Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. |
| DAPP31 | 97 | Service Not Paid on Independently Billed Claims | The benefit for this service is included in the payment/allowance for another service/procedure that has already been |
| DAPP32 | 151 | Minimum Required Units Not Met/Maximum Allowed Units Exceeded | Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. |
| DAPP38 | 97 | Payment Bundled with Other AMCC Test | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DAPP94 | 16 | Invalid Dates | Claim/service lacks information which is needed for adjudication. |
| DAS | 16 | DAS-Admission source required | Claim/service lacks information which is needed for adjudication. |
| DASP22 | A1 | DASP22-Denial Claim; Bill Type ending in 0 or CC 20, 21 | Claim/service denied. |
| DASP23 | 16 | DASP23-Invalid Service Date, From-Thru Dates, or Admission Date | Claim/service lacks information which is needed for adjudication. |
| DASP24 | 16 | DASP24-ACE Suspension, RTP, Denial or Rejection | Claim/service lacks information which is needed for adjudication. |
| DASP25 | 16 | DASP25-Invalid Partial Hospitalization Claim | Claim/service lacks information which is needed for adjudication. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DASP26 | 16 | DASP26-Invalid Credit/Adjustments Claim | Claim/service lacks information which is needed for adjudication. |
| DASP37 | 16 | DASP37-Invalid Billing of Codes for Cardiac Resynchronization Therapy | Claim/service lacks information which is needed for adjudication. |
| DASP41 | 16 | DASP41-Invalid Billling of Therapy Services | Claim/service lacks information which is needed for adjudication. |
| DASP42 | 16 | DASP42-Invalid Billing of Device Credit | Claim/service lacks information which is needed for adjudication. |
| DASP54 | 4 | DASP54-Biosimilar HCPCS Reported without Biosimilar Modifier | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DASP94 | 16 | DASP94-Invalid Dates | Claim/service lacks information which is needed for adjudication. |
| DAT | 16 | DAT-Invalid/missing admission type | Claim/service lacks information which is needed for adjudication. |
| DBCA | 45 | DBCA-Billed amount exceeds contractual | Charge exceeds fee schedule/maximum |
| DBH01 | N34 | Invalid Form Type | Incorrect claim form/format for this service. |
| DBH02 | 16 | Missing Rate Code | Claim/service lacks information which is needed for adjudication. |
| DBH03 | 16 | Multiple Rate Codes | Claim/service lacks information which is needed for adjudication. |
| DBH04 | 16 | Invalid Rate Code | Claim/service lacks information which is needed for adjudication. |
| DBH05 | N56 | Invalid Procedure Code | Procedure code billed is not correct/valid for the services billed or the date of service billed. |
| DBH06 | 16 | Invalid Units or Modifiers | Claim/service lacks information which is needed for adjudication. |
| DBH08 | B7 | Invalid Provider Certification | This provider was not certified/eligible to be paid for this procedure/service on this date of service. |
| DBI | 109 | DBI-Not UBA - Bill Insurer | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DBID | 16 | DBID- Resubmit with the baby's ID number. | Claim/service lacks information which is needed for adjudication. |
| DBW | 16 | DBW-Claim requires submission of baby's birth weight in Value Code fields. | Claim/service lacks information which is needed for adjudication. |
| DCAT | 96 | DCAT-No Reimbursement for Category II or III codes | Non-covered charges. |
| DCB | 18 | DCB-Global Service previously paid | Duplicate claim/service. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DCHNAS | A1 | DCHNAS-Non-allowable Children's Health and Behavioral Health service combination has been identified. Service will be referred for clinical review. | Claim/service denied. |
| DCHNAS | 96 | DCHNAS-Non-allowable Children's Health and Behavioral Health service combination has been identified. Service will be referred for clinical review. | Non-covered charges. |
| DCLF | 96 | DCLF-Per CMS, no reimbursement can be made for this 2015 clinical lab service. Please resubmit with an alternate HCPCS G code or Chemistry CPT code for drug screening/testing. | Non-covered charges. |
| DCMS | 96 | DCMS-Per CMS Guidelines, no reimbursement can be made for these services. | Non-covered charges. |
| DCON | 96 | DCON-Consult codes invalid per CMS. Please rebill with an E&M code. | Non-covered charges. |
| DCRP | 24 | DCRP-Case Rate Payment Previously Paid For DOS. | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| DCUST | 39 | DCUST-Authorization Denied. Custodial Level of Care is not covered. | Services denied at the time authorization/pre-certification was requested. |
| DCV | 109 | Covered by NYS and NYC Child Vaccine Program | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DD50 | 4 | DD50-Invalid Bilateral modifier | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DDA | 23 | DDA-Other coverage disallowed | The impact of prior payer(s) adjudication including payments and/or adjustments. |
| DDDS | 16 | DDDS-Need Individual DOS | Claim/service lacks information which is needed for adjudication. |
| DDI | 47 | DDI-Invalid ICD-9 Code | |
| DDIG | 4 | DDIG-Added TC or 26 Mod | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DDS | 152 | DDS-DOS after discharge | Payer deems the information submitted does not support this length of service. |
| DDSU | A1 | DDSU-Supply on date of surgical procedure | Claim/service denied. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DDUC | 4 | DDUC-CPT Paid with 50 Mod | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DDX | 47 | DDX-Invalid ICD9 diagnosis code | |
| DDXP | 47 | DDXP-Invalid diagnosis code for service billed | |
| DE1 | 109 | DE1-Contact Health Plan for Accupuncture Benefits | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DE10 | 50 | DE10-Services Not Considered Medically Necessary | These are non-covered services because this is not deemed a "medical necessity" by the payer. |
| DE11 | 96 | DE11-Non Covered Vision Services | Non-covered charges. |
| DE16 | 96 | DE16-Non Covered In Vitro Fertilization | Non-covered charges. |
| DE2 | 96 | DE2-Non Covered Blood Products | Non-covered charges. |
| DE3 | 109 | DE3-Contact Health Plan for Chiropractic Benefits | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DE32 | 96 | DE32-Non Covered Transportation | Non-covered charges. |
| DE33 | 96 | DE33-Non Covered Hearing Services | Non-covered charges. |
| DE4 | 96 | DE4-Non Covered Cosmetic Procedures | Non-covered charges. |
| DE40 | 96 | DE40-Services Non Covered by Medicare Guidelines | Non-covered charges. |
| DE41 | 8 | DE41-Provider specialty invalid for this type of service | The procedure code is inconsistent with the provider type/specialty (taxonomy). |
| DE42 | 109 | DE42-Payable by Medicaid Fee For Service | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DE43 | 109 | DE43-VAMC Claim - Medicare Member | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DE44 | 109 | DE44-VAMC Claim - Medicaid Member | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DE6 | 109 | DE6-Dental Services are not covered - Bill the Member's Dental Carrier or the Health Plan/Insurer | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DEB | D16 | DEB-Submit primary eob | |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DECUP | 216 | DECUP-Decision Upheld | Based on the findings of a review organization |
| DER | 45 | DER-E/R paid at global rate | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| DFAC | 96 | DFAC-DFAC-Service non-covered under statutory definition of "physician services" for fee schedule payment purposes. | Non-covered charges. |
| DFD | 110 | DFD-DOS indicated not valid/incorrect | Billing date predates service date. |
| DFEE | 147 | DFEE-FEE NOT ON FILE | Provider contracted/negotiated rate expired or not on file. |
| DFV | 101 | DFV-Scanning Error Correction | Predetermination: anticipated payment upon completion of services or claim adjudication. |
| DGA | 8 | DGA-GenAnesNonAnesSpecty | The procedure code is inconsistent with the provider type/specialty (taxonomy). |
| DGDI | 10 | DGDI-Diagnosis invalid for gender | The diagnosis is inconsistent with the patient's gender. |
| DGDP | 7 | DGDP-Service invalid for gender | The procedure/revenue code is inconsistent with the patient's gender. |
| DHHA | 16 | DHHA-Please resubmit with the required Rev Code 0023 service line and HIPPS code. | Claim/service lacks information which is needed for adjudication. |
| DHP | 109 | DHP-Health Plan responsibility | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DHS | B9 | DHS-Hospice related services | Patient is enrolled in a Hospice. |
| DIAD | 109 | DIAD-IAD Payable by Medicare | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DIALY | 125 | DIALY-Dialysis Billing error | Submission/billing error(s). |
| DID4 | D18 | DID4-Diag Reg 4/5th Digit | |
| DINR | 16 | DINR-Requested information not received. | Claim/service lacks information which is needed for adjudication. |
| DINV | 16 | DINV-Please submit a paper invoice for this service to CMO Special Handling Unit | Claim/service lacks information which is needed for adjudication. |
| DIPC | B18 | DIPC-Invalid ICD9 Procedure Code | |
| DIR | D19 | DIR-Additional information required | |
| DLA | 96 | DLA-Local Anesthesia not covered | Non-covered charges. |
| DME | 125 | DME Billing errors | Submission/billing error(s). |
| DMH | 96 | DMH-Non- medical benefit (UBA) | Non-covered charges. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DMHE | 47 | DMHE-Mental Health Coding Denied | |
| DMLT | 109 | DMLT-Resubmit to HealthFirst All Dates of Service Prior to 2/01/16 | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DMN | 50 | DMN-Medical record reviewed; medical necessity was not established. | These are non-covered services because this is not deemed a "medical necessity" by the payer. |
| DMNR | 133 | DMNR - Medical record received; under medical necessity review. | The disposition of the claim/service is pending further review. |
| DMOD | 4 | DMOD-Please submit anesthesia modifier code(s) | The procedure code is inconsistent with the modifier used or a required modifier is missing. |
| DMOM | 128 | DMOM-Resubmit with the Mother's ID | Newborn's services are covered in the mother's Allowance. |
| DMP | D16 | DMP-Submit Medicare EOMB | |
| DMR | 96 | DMR-Member responsibility | Non-covered charges. |
| DNBC | A1 | DNBC-Deny add-on no base code | Claim/service denied. |
| DNCC | M50 | Rev Code not covered under the contract. Resubmit with valid code per your contract. | Missing/incomplete/invalid revenue code(s). |
| DNCD | 147 | DNCD-Service non-contracted for the date of service | Provider contracted/negotiated rate expired or not on file. |
| DNCP | 96 | DNCP-Procedure Code Not Covered | Non-covered charges. |
| DNCS | 52 | DNCS-Non contracted service | |
| DNDCMI | M119 | DNDCMI-Submit drug description, including NDC number, quantity, unit of measure | Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). |
| DNEG | 131 | DNEG-Negotiated rate | Claim specific negotiated discount. |
| DNM | 96 | DNM-Non- MH benefit (UBA) | Non-covered charges. |
| DNP | B7 | DNP-Non covered provider | This provider was not certified/eligible to be paid for this procedure/service on this date of service. |
| DNPE | 52 | DNPE-No provider eligibility | |
| DNPI | 16 | DNPI-NPI Mismatch. Resubmit with valid NPI's for Billing and Servicing Providers. | Claim/service lacks information which is needed for adjudication. |
| DNST | A1 | DNST-SurgTrayDeny-NoValCd | Claim/service denied. |
| DOC | 22 | DOC-Other Covg Possible | This care may be covered by another payer per coordination of benefts. |
| DOM | 38 | DOM-Service not authorized, OON provider (UBA) | Services not provided or authorized by designated (netowrk/primary care) providers. |
| DOP | D19 | DOP-Please submit operative report | |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DOPG01 | M20 | DOPG01-Code is Invalid, or Not Valid for Service Date | Missing/incomplete/invalid HCPCS. |
| DOS | 16 | DOS-Date of Service correction | Claim/service lacks information which is needed for adjudication. |
| DOSE | 96 | DOSE-Non-covered for reasons other than statutory exclusion. | Non-covered charges. |
| DOTR | D19 | DOTR-Outpatient treatment report required (UBA) | |
| DPBP | 101 | DPBP-Payment being processed | Predetermination: anticipated payment upon completion of services or claim adjudication. |
| DPD | 109 | DPD-Claim being processed by Plan under Member's Part D Benefit | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DPD | | Claim being processed by Plan under the Member's Part D | |
| DPEC | 51 | DPEC-Pre-existing condition | These are non-covered services because this is a pre-existing condition. |
| DPER | 51 | DPER-Pre-existing research | These are non-covered services because this is a pre-existing condition. |
| DPIN | B8 | DPIN-Procedure Invalid for Medicare purposes. Medicare uses another code for reporting of these services. | Alternative services were available, and should have been utilized. |
| DPN | 16 | DPN-Invalid provider, name required | Claim/service lacks information which is needed for adjudication. |
| DPOA | 16 | Diagnosis requires POA indicator | Claim/service lacks information which is needed for adjudication. |
| DPP | 109 | DPP-Paid by health plan | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DPWH | 16 | DPWH-Claim requires submission of Patient Weight and Patient Height in the Value Code fields. | Claim/service lacks information which is needed for adjudication. |
| DRA | B20 | DRA-MemReassignforMBCIPA | Procedure/service was partially or fully furnished by another provider. |
| DRB | 16 | DRB-Units/days exceed admission days | Claim/service lacks information which is needed for adjudication. |
| DRC | 16 | DRC-Invalid revenue code | Claim/service lacks information which is needed for adjudication. |
| DREV | 16 | Please resubmit with the required valid | Claim/service lacks information which is |
| DRF | 96 | DRF-Routine foot care-Not Covered Benefit | Non-covered charges. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DRGP02 | 16 | DRG02 - No DRG Rate Record found | Claim/service lacks information which is needed for adjudication. |
| DRGP04 | 16 | DRGP04 - Invalid Payer Type | Claim/service lacks information which is needed for adjudication. |
| DRGP13 | 16 | DRGP13 - Admit Date Equals Discharge Date | Claim/service lacks information which is needed for adjudication. |
| DRGP14 | 16 | DRGP14 - Invalid DRG Pricing Option; allowable options are selected through the DRG Pay type on the DRG Rate file. | Claim/service lacks information which is needed for adjudication. |
| DRGP15 | 16 | DRGP15 - Invalid Tier Start Days. Start day for tier 1 must be >0 and each subsequent tier start day must be > than the previous tier. | Claim/service lacks information which is needed for adjudication. |
| DRGP16 | 16 | DRGP16 - Invalid ALC Days/Interrupted Days/Non-covered days | Claim/service lacks information which is needed for adjudication. |
| DRGP17 | 16 | DRGP17 - Number of ECT treatments not coded on a service line with Rev Code 0901. | Claim/service lacks information which is needed for adjudication. |
| DRGP18 | 16 | DRGP18 - Invalid Occurrence Span Date | Claim/service lacks information which is needed for adjudication. |
| DRGP19 | 16 | DRGP19 - ECT Units Coded without Appropriate ICD-10 PCS Procedure | Claim/service lacks information which is needed for adjudication. |
| DRGP20 | 16 | DRGP20 - Requested Inpatient PPS Rate information cannot be found. | Claim/service lacks information which is needed for adjudication. |
| DRGP21 | 16 | DRGP21 - Invalid/Missing Present on Admission (POA) Indicator | Claim/service lacks information which is needed for adjudication. |
| DRGP24 | 96 | DRGP24 - Non-Covered Claim | Non-covered charges. |
| DRGP25 | 96 | DRGP25 - Non-Payment Claim | Non-covered charges. |
| DRGP26 | 96 | DRGP26 - Claim Contains a Never Event or an Adverse Event | Non-covered charges. |
| DRGP27 | 96 | DRGP27 - Wrong Procedure performed. | Non-covered charges. |
| DRGP62 | - | DRGP62 - Closed or Inactive Rate Record | |
| DRGT | A1 | DRGT-ReplaceGlob/TechComp | Claim/service denied. |
| DRP | 172 | DRP-Rollover pay not due (UBA) | Payment is adjusted when performed/billed by a provider of this specialty. |
| DRR | 38 | DRR-UBA referral required | Services not provided or authorized by designated (network/primary care) providers. |
| DSAN | B7 | DSAN-CMS Sanction Period | This provider was not certified/eligible to be paid for this procedure/service on this date of service. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| DSED | 109 | DSED-SED Carveout, Bill State (UBA) | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| DSNF | 16 | Please resubmit with the required Rev Code 0022 service line and HIPPS code. | Claim/service lacks information which is needed for adjudication. |
| DSP | A1 | DSP-Please submit paper claim | Claim/service denied. |
| DST | 131 | DST-Provider settlement | Claim specific negotiated discount. |
| DTB | 16 | DTB-Invalid type of bill | Claim/service lacks information which is needed for adjudication. |
| DTI | 150 | DTI-Anesthesia time required | Payer deems the information submitted does not support this level of service. |
| DTIN | B7 | DTIN - Provider TIN not active for DOS | This provider was not certified/eligible to be paid for this procedure/service on this date of service. |
| DTR | 96 | DTR-Non covered transportation | Non-covered charges. |
| DUCR | 45 | DUCR-Charges submitted exceed the usual, customary, and reasonable amount or prevailing rate for the geographic area. Payment has been reduced to the prevailing rate. | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| DUP | 18 | DUP-Services provided by unlicensed provider | Duplicate claim/service. |
| DVC | 16 | DVC-Invalid Value Code | Claim/service lacks information which is needed for adjudication. |
| DX | 16 | DX-Diagnosis Code correction | Claim/service lacks information which is needed for adjudication. |
| EB | 23 | EB-Primary EOB submitted, pay as secondary | The impact of prior payer(s) adjudication including payments and/or adjustments. |
| ENC | 24 | ENC-Encounter Not Claim | Charges are covered under a capitation agrement/managed care plan. |
| EXO | 95 | EXO-Exclusion Override | Plan procedures not followed. |
| HAF | B20 | HAF-Half Reassignment - MBCIPA | Procedure/service was partially or fully furnished by another provider. |
| ICO | 95 | ICO-IntelliClaim rule override | Plan procedures not followed. |
| IIS | 16 | IIS-Incorrect information submitted on the original claim | Claim/service lacks information which is needed for adjudication. |
| IPREAD | 249 | IPREAD-Inpatient Readmission denial | This claim has been identified as a readmission. |
| LTCHG | 125 | LTCHG-Late Charges | Submission/billing error(s). |
| M0016 | 96 | M0016-Non-covered benefit | Non-covered charges. |
| M0200 | 96 | M0200-Non-covered benefit | Non-covered charges. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| M100 | 109 | RESUBMIT CLAIM TO ANTHEM - RADIOLOGY VENDOR (AIM) | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M101 | 109 | RESUBMIT CLAIM TO ANTHEM - VENDOR (ASH) | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M102 | 109 | RESUBMIT CLAIM TO ANTHEM - VENDOR Logisticare | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M103 | 109 | RESUBMIT CLAIM TO ANTHEM - HEARING VENDOR (HCS) | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M104 | 109 | RESUBMIT CLAIM TO VENDOR - LIBERTY DENTAL PLAN | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M105 | 45 | Pending QualCare Pricing UB Claims | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M106 | 109 | Resubmit Claim to Vendor - Healthplex Dental plan | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M107 | 109 | Resubmit claim to Vendor - Superior Vision | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M108 | 109 | Resubmit claim to Vendor - Orthonet | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M109 | 109 | Resubmit claim to Vendor - Healthplex | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M110 | 109 | Resubmit claim to MVP | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M111 | 45 | Medicaid Children Transformation Validation and Pricing | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M112 | 45 | Aligned HCBS Validation and Pricing | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M113 | 96 | Non-Covered Benefit | Non-covered charges. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| M114 | 109 | Claim received and sent to Beacon Health Options for processing | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M200 | 96 | CMS Preventive Care Non Covered OON | Non-covered charges. |
| M34 | A1 | Non Contracted Services Denied per HIP | Claim/service denied. |
| M37 | 45 | Case Rate for PTOTST Services Rendered at POS 62 | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M38 | 45 | Case Rate Payment for an Initial Visit by an Ophthalmologist or an Optometrist | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M39 | 45 | Case Rate Payment for a Follow-Up Visit by and Ophthalmologist or an Optometrist | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M40 | 96 | Medicare non covered DME | Non-covered charges. |
| M41 | 96 | Medicare Non Covered Supplies | Non-covered charges. |
| M42 | 97 | Professional Services are included in the global payment | The benefit for this service is included in the payment/allowance for another service/procedure that has already been |
| M43 | 97 | All Inclusive Payment | The benefit for this service is included in the payment/allowance for another service/procedure that has already been |
| M44 | 109 | Service Payable by Medicare Directly | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M45 | 109 | Health Plan Responsibility | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M48 | 45 | Case Rate for PTOTST Services | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M49 | 45 | Case Rate Payment for Podiatry Services | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M50 | 45 | Case Rate Payment for MH Services | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M53 | 109 | Covered by NYS and NYC Child Vaccine Program | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| M54 | 97 | NYCDOH Bundled Rate | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| M56 | 45 | Case Rate Payment for Home Health Care Services | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M57 | 109 | Services payable directly by Medicaid | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M58 | 45 | Case Rate Payment for ER Services | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M59 | 45 | HIP Case Rate for Non-APC priced services | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M62 | A1 | DME Rider Required for Coverage | Claim/service denied. |
| M63 | 45 | Comprehensive eye Exam maximum per visit payment | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M65 | 45 | Services paid according to contracted rate | allowable or contracted/legislated fee |
| M67 | 96 | Routine Foot Care - Not a Covered Benefit | Non-covered charges. |
| M71 | 96 | Medicaid Non Covered Supplies | Non-covered charges. |
| M72 | 109 | Resubmit to Value Options, PO Box 803, Latham, NY 12210 | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M73 | 96 | Non Contracted Mental Health Services | Non-covered charges. |
| M74 | 109 | Services administered by Block Vision | Claim/service not covered by this |
| M77 | 96 | Non-Covered E&M codes prior to 1/1/2013 | Non-covered charges. |
| M78 | 45 | Visit Limit Exceeded | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M79 | 96 | Medicaid OB Non Covered Service. Resubmit with Valid Dx and Modifier. | Non-covered charges. |
| M80 | 96 | Non-Covered Services for Out-Of-Network Providers | Non-covered charges. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| M81 | 96 | Medicaid Non Covered diagnosis. | Non-covered charges. |
| M82 | 109 | Resubmit claim directly to Health Plan, Affinity. | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M83 | 96 | Invalid Clinic CPT code - Eff. 1/1/14, OPD Clinic visits should be billed with HCPCS code G0463. | Non-covered charges. |
| M84 | 109 | Resubmit claim directly to Health Plan, Health First. | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M85 | 96 | Non-Covered Services for In-Netowrk Providers. | Non-covered charges. |
| M88 | 96 | Non-Covered HARP services. | Non-covered charges. |
| M89 | 45 | PHX Facility Pricing Required | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M90 | 45 | Pending Medicaid BH Mainstream Validation and Pricing | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M91 | 22 | Medicare Primary Payor | This care may be covered by another payer per coordination of benefits. |
| M92 | 96 | Non-Covered Vision Hardware | Non-covered charges. |
| M93 | 45 | MLTC Transportation pricing Required | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M94 | 109 | Resubmit to EyeMed, PO Box 8504, Mason, OH 45040 | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M95 | 45 | Pending QualCare Pricing HCFA Claims | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |
| M96 | 109 | ANTHEM RESPONSIBLE FOR PROCESSING PAYMENT | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M97 | 96 | Non-Covered DME and Supplies | Non-covered charges. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| M98 | 109 | RESUBMIT CLAIM TO VENDOR - BlueView Vision (EyeMed) | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| M99 | 109 | RESUBMIT CLAIM TO ANTHEM - LAB VENDOR QuestNet | Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. |
| MDG | A8 | MDG-Medicare DRG submitted for Commercial member | Ungroupable DRG. |
| MOD | 182 | MOD-Modifier correction | Procedure modifier was invalid on the date of service. |
| NAMIGC | 96 | NAMIGC-NAMI payment greater than eligible payment amount. | Non-covered charges. |
| NDCIN | M119 | NDC Invalid | Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). |
| NDCPN | M119 | NDC Inappropriate for HCPCS code | Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC). |
| NOPR | 109 | NOPR-Denied NOPR. Bill Medicare. | Claim/service not covered by this |
| OP | 95 | OP-Op Report/Proc. Description Received | Plan procedures not followed. |
| OPIP | 60 | OPIP-Outpatient charges Biled during Inpatient stay | Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services. |
| OTR | 17 | OTR-No OTR Received - MBCIPA | |
| OVPAY | 216 | OVPAY-Overpayment due to manual or system error | Based on the findings of a review organization |
| PAYMOD | 216 | PAYMOD-Modifiers affecting Payment error | Based on the findings of a review organization |
| PCP | 172 | PCP-PCP Paid as SCP in error | Payment is adjusted when performed/billed by a provider of this specialty. |
| PDIEM | 216 | PDIEM-Per Diem Payment error | Based on the findings of a review organization |
| POS | 5 | POS-Place of Service correction | The procedure code/bill type is inconsistent with the place of service. |
| PRO | 16 | PRO-Procedure Code correction | Claim/service lacks information which is needed for adjudication. |
| R07 | A1 | R07-Claim Denied | Claim/service denied. |
| REA | B20 | REA-Reassignment - MBCIPA | Procedure/service was partially or fully furnished by another provider. |
| RED | 45 | Eff. 10/1/15, new Medicaid 25% payment reduction applies. | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| REV1 | - | REV1-Deductible/Coinsurance amount(s) incorrect | |
| REV11 | - | REV11-HP Rate Received Retroactively | |
| REV12 | - | REV12-HP Provided Incorrect Rate | |
| REV13 | - | REV13-IPA Contracted Rate Received Retroactively | |
| REV14 | - | REV14-Manual Pricing Error Correction | |
| REV15 | - | REV15-Member Eligiblity updated | |
| REV17 | - | REV17-Duplicate claim - previously denied | |
| REV18 | - | REV18-Duplicate claim - previously paid | |
| REV19 | - | REV19-HP Audit Error Correction | |
| REV2 | - | REV2-Incorrect Provider/Group paid | |
| REV20 | - | REV20-CMO Quality Audit Error Correction | |
| REV22 | - | REV22-Benefit maximum has been reached | |
| REV23 | - | REV23-Benefit Information received from HP incorrect | |
| REV3 | - | REV3-Co-payment amount(s) incorrect | |
| REV30 | - | REV30-Denial reversed per Medical Review | |
| REV31 | - | REV31-Claim denied in error | |
| REV32 | - | REV32-Claim paid in error | |
| REV33 | - | REV33-Claim paid to incorrect address | |
| REV34 | - | REV34-Stop-pay issued. Claim reprocessed | |
| REV35 | - | REV35-Claim denied as duplicate. Not a duplicate. | |
| REV36 | - | REV36-Over/Under payment adjustment | |
| REV37 | - | REV37-Check Voided. Claim(s) reprocessed | |
| REV38 | - | REV38-No Auth/Referral required | |
| REV39 | - | REV39-Receipt Date Entered Incorrectly | |
| REV4 | - | REV4-Balance Billing on Out of Network service | |
| REV40 | - | REV40-Provider Information Updated | |
| REV41 | - | REV41-COB Information updated | |
| REV42 | - | REV42-Medicare Secondary Payer Adjustment Amount | |
| REV43 | - | REV43-Auto-related injury/No-Fault | |
| REV44 | - | REV44-Workers Compensation case | |
| REV45 | - | REV45-Other coverage primary | |
| REV46 | - | REV46-Reversal - Member Appeal | |
| REV47 | - | REV47-Retroactive receipt of referral | |
| REV48 | - | REV48-Incorrect Member/ID Selected | |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| REV49 | - | REV49-Reversal - Provider Appeal | |
| REV5 | - | REV5-Corrected Bill Submitted | |
| REV50 | - | REV50-IPA termed contract | |
| REV51 | - | REV51-EHIP Pricing Error | |
| REV52 | - | REV52-Compliance with Bill 8417 | |
| REV53 | - | REV53-Cash Receipt Refund | |
| REV54 | - | REV54-Bioscript RX Cancellation | |
| REV55 | - | REV55-CMO is Primary | |
| REV56 | - | REV56-Admission/visit cancelled | |
| REV57 | - | REV57-Full recoupment of initial payment. Payment adjustment will follow on this or a future eob. | |
| REV58 | - | REV58-VA Recoupment | |
| REV59 | - | REV59-HSR Credit Balance | |
| REV6 | - | REV6-Procedure code inconsistent with patient's age | |
| REV60 | - | REV60-Hospice CMO Not Primary | |
| REV61 | - | REV61-COB Systemic Reversal | |
| REV62 | - | REV62-Bronx VA Project | |
| REV63 | - | REV63-Project; duplicate takebacks | |
| REV7 | - | REV7-Procedure code inconsistent with patient's sex | |
| REV8 | - | REV8-CCMS Auth updated after claim process date | |
| REV9 | - | REV9-Diagnosis inconsistent with patient's age | |
| REVAIS | - | REVAIS-Auth in system when claim was processed | |
| REVCOB | - | REVCOB-Reversal-Cotiviti COB | |
| REVCOT | - | REVCOT-Reversal-Cotiviti Recovery | |
| REVMEDP | - | REVMEDP - Cotiviti Medical Policy Appeal - Decision reversed | |
| REVREL | - | REVREL-Reversal-Retro Eligibility | |
| SCP | 172 | SCP-SCP Paid as PCP Encounter | Payment is adjusted when performed/billed by a provider of this specialty. |
| SY | A1 | SY-System Modification Error | Claim/service denied. |
| TFA | 29 | TFA-Timely Filing - Administrative decision | The time limit for filing has expired. |
| TFD | 29 | TFD-Timely Filing - Documentation received | The time limit for filing has expired. |
| TMEMB | 27 | TMEMB-Claims paid for Termed Members | Expenses incurred after coverage terminated. |
| TOS | A1 | TOS-Incorrect TOS selected | Claim/service denied. |

## QNXT Remit Reasons to HIPAA Remit Reason Codes Mapping

| QNXT Deny Reason Code | HIPAA Remit Code | QNXT Remit Reason Description | HIPAA Remit code description |
|---|---|---|---|
| TRANSP | 96 | Non-Emergency Transportation Not Covered | Non-covered charges. |
| TXFREQ | 151 | TXFREQ-Service Not Rendered/Treatment Frequency error | Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. |
| UGLOB | 97 | UGLOB-Professional services part of behavioral health facility fee | The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. |
| UNI | 16 | UNI-Units Correction | Claim/service lacks information which is needed for adjudication. |