Claim Denial Code Cheat Sheet

The codes practices see most, what they mean and the first thing to check

Find the code on your remittance (ERA 835 or EOB), read the remark code (RARC) next to it, then use the first step below. Each code has a full page with causes, fixes and prevention at rcmbilling.us/denial-codes.

Code	What it means	First thing to check
CO-4	Procedure code and modifier do not match	Read the remark code and the payer's modifier policy for that procedure
CO-11	Diagnosis does not match the procedure	Compare the claim lines and diagnosis pointers with the documentation
CO-15	Authorization number missing or invalid	Find the approval in your records and compare its provider, codes and dates with the claim
CO-16	Claim lacks information or has an error	Read the remark code (RARC) with the denial. It usually names the missing item
CO-18	Duplicate claim or service	Check the status of the original claim before doing anything
CO-22	Another payer may be responsible	Ask the patient about all coverage and confirm the order of benefits
CO-24	Covered under a capitation agreement	Verify who the patient is assigned to and whether the service falls under capitation
CO-27	Coverage had ended	Run an eligibility check for the date of service
CO-29	Time limit for filing has expired	Check the payer's filing limit and the dates you submitted and corrected the claim
CO-31	Patient cannot be identified as insured	Run an eligibility check with the exact details on the card
CO-45	Charge exceeds the fee schedule or contracted rate	Compare the payment with your contract's allowed amount
CO-50	Not medically necessary	Read the denial and the payer's coverage policy for the service
CO-96	Non-covered charge	Read the remark code and the plan's benefits for the service
CO-97	Included in the payment for another service	Check the NCCI edit or payer policy for the code pair
CO-109	Claim sent to the wrong payer	Run an eligibility check to find who should be billed
CO-119	Benefit maximum reached	Check the patient's benefits and how many visits or dollars were used
CO-140	Patient ID and name do not match	Run an eligibility check using the exact card details
CO-151	Information does not support this many or this frequent services	Compare units and dates with the payer's frequency policy
CO-167	Diagnosis not covered	Check the payer's coverage policy and its list of covered diagnoses
CO-197	Authorization or precertification absent	Find out whether an authorization exists and under which number
CO-204	Service not covered under the current plan	Verify the patient's current benefits for the service
CO-252	Attachment or documentation required	Read what the payer asked for and its deadline
PR-1, 2, 3	Patient owes deductible, coinsurance or copay	Post the payer's payment and move the PR amount to patient responsibility

Group codes: CO means contractual obligation (generally not billable to the patient; check your contract and state rules). PR means patient responsibility. Code descriptions are plain-language summaries. The official list is maintained by X12 and updated regularly, so always read the remark code and the payer's policy. General information only, not legal or coding advice.