

Top 50 Medical Billing Denial Codes

What each denial means • Why it happens • How to fix it fast

CO Codes — Contractual Obligation (Payer Adjustments)

Code	Denial Name	Why It Happened	How to Fix It
CO-4	Procedure code not matching modifier	Modifier used doesn't match the billed procedure.	Check and correct the modifier. Resubmit with the right one.
CO-11	Diagnosis code doesn't match the procedure	The diagnosis is not a valid reason for the service billed.	Update the diagnosis code to match the procedure. Resubmit.
CO-15	Missing or wrong authorization number	Prior authorization wasn't obtained or the number is incorrect.	Get the correct auth number from the payer and resubmit.
CO-16	Claim lacks information needed to process	Required fields are blank or incorrect on the claim.	Review the rejection notice, fill in missing info, resubmit.
CO-18	Exact duplicate claim	Same claim was already submitted and processed.	Check if the original was paid. If not, appeal. Don't resubmit.
CO-19	This is a work-related injury. Bill workers' comp.	The condition appears to be work-related.	Bill the workers' compensation carrier instead.
CO-22	Coordination of Benefits – bill other payer first	Patient has another insurance that should be billed first.	Identify the primary payer, bill them first, then submit secondary claim.
CO-23	Charges submitted to wrong payer	The claim was sent to the incorrect insurance company.	Identify the correct payer and resubmit to the right one.
CO-26	Expenses incurred prior to coverage	Service was done before the patient's insurance was active.	Verify coverage dates. Bill the patient if no coverage was in effect.
CO-27	Expenses incurred after coverage ended	Service was done after the patient's insurance was terminated.	Check termination date. Bill the patient or find new coverage info.
CO-29	Claim was filed too late (timely filing)	The claim wasn't submitted within the payer's allowed time frame.	Gather proof of timely filing (clearinghouse report) and appeal.
CO-31	Patient has no coverage for this service on this date	Insurance was not active on the date of service.	Verify coverage. Bill the patient or check for other insurance.
CO-45	Charge exceeds the fee schedule maximum	Billed amount is higher than what the payer allows.	This is a write-off per contract. Adjust the balance accordingly.
CO-49	Service not covered — not in plan benefits	The specific service is excluded from the patient's plan.	Notify the patient. They may owe the balance as non-covered service.
CO-50	Non-covered service — not medically necessary	Payer says the service wasn't medically necessary.	Appeal with clinical notes and medical records showing necessity.

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CO-51	Non-covered service — prior to deductible	Patient's deductible hasn't been met yet.	Bill the patient for the deductible amount.
CO-55	Procedures done at same time — not separately billable	Two procedures were billed that can't be billed together.	Review NCCI edits. Remove the bundled code or appeal with documentation.
CO-56	Procedure requires qualifying service not yet received	A required prior visit or service wasn't done first.	Review the sequence of care. Reschedule or document appropriately.
CO-58	Treatment was not pre-certified	The service needed pre-certification but didn't have one.	Contact payer about retroactive auth, or appeal with medical records.
CO-59	Procedures were not billed appropriately together	Distinct procedures weren't properly documented as separate.	Add modifier 59 or XE/XS/XP/XU if truly separate. Document clearly.
CO-96	Non-covered charge(s)	The billed service is excluded from coverage.	Bill patient for non-covered amount. No appeal typically possible.
CO-97	Benefit for this service is included in another service	The service is already bundled into another billed procedure.	Review billing, remove the bundled code, or add modifier if distinct.
CO-109	Claim not covered by this payer. Send to correct one.	The claim doesn't belong to this insurance company.	Find the correct payer and resubmit the claim there.
CO-119	Benefit maximum for this time period has been reached	Patient used up the max allowed visits or amount for the period.	Inform the patient. They are responsible for the remaining balance.
CO-125	Submission/billing error	General billing mistake on the claim form.	Review the entire claim carefully, fix all errors, resubmit.

CO Codes Continued + OA & PR Codes — Patient Responsibility

Code	Denial Name	Why It Happened	How to Fix It
CO-129	Prior processing information appears incorrect	Previous claim data doesn't match what's being submitted now.	Check prior claim records and resubmit with corrected information.
CO-131	Claim specific negotiated discount	A special contracted discount was applied.	Review contract terms. Write off the discount as per agreement.
CO-133	The disposition of the related Medicare claim is not known	Medicare's decision on a related claim hasn't come through yet.	Wait for Medicare's EOB, then submit the secondary claim.
CO-151	Payment denied – service deemed not reasonable or necessary	Payer determined the service wasn't medically justified.	Appeal with complete clinical documentation and treatment notes.
CO-167	Benefit is not covered by this payer	This specific benefit isn't included in this plan.	Bill the patient or identify if another payer covers this benefit.

Code	Denial Name	Why It Happened	How to Fix It
CO-170	Payment is denied when billed without other required service	Service must be billed alongside another specific service.	Add the required companion service or procedure to the claim.
CO-177	Patient has not met the required eligibility requirements	Patient doesn't qualify for this benefit under the plan rules.	Verify eligibility. Bill patient if they don't qualify.
CO-197	Missing or incomplete precertification	Prior auth was required but not completed properly.	Obtain retroactive auth or appeal with clinical records.
CO-204	Service, equipment, or drug not covered	This item is not a benefit under the patient's current plan.	Check the plan's benefit list. Bill patient or find other coverage.
CO-222	Exceeds the contracted maximum number of hours/days/units	Billed more than the plan allows for this type of service.	Reduce to the allowed amount or appeal if medically necessary.
CO-226	Information requested from patient was not provided	Patient didn't send required information to the insurer.	Contact the patient. Help them provide what the payer requested.
OA-18	Exact duplicate claim or service	Claim already processed — duplicate submission detected.	Confirm payment of original. Void the duplicate if needed.
OA-23	Payment adjusted because charges have been paid by another payer	Another insurer already paid this claim.	Apply the payment from the primary payer. Adjust the balance.
PR-1	Deductible amount	Patient hasn't met their deductible yet.	Bill the patient for the deductible portion.
PR-2	Coinsurance amount	Patient owes their percentage of the coinsurance.	Bill the patient for the coinsurance amount.
PR-3	Copayment amount	Patient owes a fixed copay for this service.	Collect the copay from the patient.
PR-26	Expenses incurred prior to coverage	Service was before the patient's insurance started.	Bill the patient directly for this date of service.
PR-27	Expenses incurred after coverage terminated	Insurance ended before this service was done.	Bill the patient directly or locate new coverage details.
PR-96	Non-covered charges — patient is responsible	Service isn't covered, so the patient owes the amount.	Send patient a statement for the non-covered balance.
PR-204	Service is not covered under this plan	The service isn't in the plan's benefit list.	Bill patient or check for supplemental coverage.
B7	Provider was not certified on this date of service	The rendering provider wasn't credentialed with the payer on that date.	Verify credentialing dates. Appeal or rebill once credentialed.
B9	Rendering provider is not authorized to bill this service	Provider type can't bill for this procedure under this payer.	Check provider agreement. Bill through a qualified provider.

Code	Denial Name	Why It Happened	How to Fix It
N30	Patient ineligible for this service	Patient doesn't meet requirements for this specific benefit.	Review eligibility. Bill the patient if appropriate.
N104	Missing/incomplete service authorization/pre certification	Auth wasn't obtained before the service was rendered.	Request retro auth or appeal with supporting documentation.
N115	This decision was based on a national coverage determination	Medicare has a national policy that applies here.	Review the specific NCD. Modify the claim or provide ABN if needed.

Quick Tips for Reducing Denials

- ✓ Verify eligibility before every visit — a simple check prevents PR-1, PR-2, CO-31 denials.
- ✓ Get prior auth early — CO-15, CO-58, CO-197 are all auth-related and fully preventable.
- ✓ Check NCCI edits before billing multiple procedures — avoids CO-55, CO-59, CO-97.
- ✓ Track filing deadlines per payer — CO-29 (timely filing) is one of the easiest to prevent.
- ✓ Train front desk on insurance cards — catching wrong payer info stops CO-22, CO-23 instantly.

For internal billing team use only • Always verify payer-specific rules • Codes subject to annual updates